Evaluation of the TRICARE Program

FY 2004 Report to Congress

TRICARE

Evaluation of the TRICARE Program

March 1, 2004

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A MESSAGE FROM WILLIAM WINKENWERDER, JR., MD, MBA

The mission of the Military Health System (MHS) in supporting the security of our nation is reflected in our commitment to individual and unit medical readiness to ensure the health and well-being of our active component and mobilized Reserve and Guard personnel. The Surgeons General of the Army, Navy, and Air Force and I are fully committed to the philosophy that the health and well-being of our fighting forces extend to the care and wellness of their family members, retirees, and their family members. These beneficiaries are integral to mission readiness and to the recruitment and retention of soldiers, sailors, airmen, and marines. The successful performance of our TRICARE health benefits program is instrumental in accomplishing this mission.

I am pleased to provide Congress with this annual report assessing the effectiveness of TRICARE performance between Fiscal Years (FY) 2001 and 2003 in improving the access to and quality of health care received by our eligible beneficiaries. This report responds to the National Defense Authorization Act (NDAA) for FY 1996 (Section 717) requiring such an assessment following the 1994 evolution, development, and deployment of the TRICARE managed care program expanding the traditional Department of Defense (DoD) indemnity medical benefit then known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This report continues to follow the approach of the past three years by comparing TRICARE with civilian-sector benchmarks, where appropriate and available, and evaluating trends over time to identify relevant changes. Additionally, this report reflects my commitment to a disciplined focus on performance results based on targeted metrics. As such, this year it includes many of the Balanced Scorecard metrics I rely on to measure near- and mid-term performance in those areas determined as critical to our longer-term TRICARE goals. I firmly believe the linkage of TRICARE performance through standardized metrics is critical to achieving my vision for a world-class MHS.

MISSION

To enhance DoD's and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

VISION

A world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health.

KEY PRIORITIES AND GOALS

- Improve force health protection and medical readiness;
- Improve performance of the TRICARE health program;
- Improve coordination, communication, and collaboration with other key entities; and
- Address issues related to the attraction, retention, and appropriate training of military medical personnel.

MHS STRATEGY ARCHITECTURE

I rely on a Balanced Scorecard approach as a useful framework for translating our MHS strategy into operational objectives to drive performance improvement in our system. This Balanced Scorecard is predicated on seven perspectives or "themes" underlying our MHS strategy as shown below: Stakeholders, Financial, External Customers, Readiness, Quality, Efficiency, and Learning and Growth (for our internal customers). These themes provide the framework for this year's report, and their supporting metrics are reflected throughout. While we track these metrics every month, they are presented in this report on an annual basis to provide clearer understanding of critical long-term trends in our performance.

MHS STRATEGY ARCHITECTURE

STAKEHOLDER PERSPECTIVE

Our stakeholders are the American people, expressed through the will of the President, Congress, and the Department of Defense.

Goals:

- To enhance DoD's and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

FINANCIAL PERSPECTIVE

Accomplish our mission in a cost-effective manner that is visible and fully accountable.

Goals:

- Determine and account for readiness costs
- Obtain appropriate resources
- Optimize stewardship of resources

EXTERNAL CUSTOMER PERSPECTIVE

Our customers are the Armed Forces and all those entrusted to our care.

Goals:

- Deliver a fit, healthy, and medically protected force
- Deliver high quality care anywhere
- Improve customer service
- Build healthy communities

INTERNAL PERSPECTIVE

READINESS THEME

Focus on activities to enhance readiness of military forces and the medical assets that support them.

Goals:

- Provide a medically ready total force
- Provide a ready medical capability

QUALITY THEME

Ensure benchmark standards for health and health care are met.

Goals:

- Improve patient safety
- Increase patient-centered focus
- Improve health outcomes

EFFICIENCY THEME

Obtain maximum effectiveness from the resources we are given.

Goals:

- Enhance system productivity
- Identify & prioritize requirements
- Improve interoperability with partners

LEARNING AND GROWTH PERSPECTIVE (INTERNAL CUSTOMERS)

Our people and our support systems are critical to giving us the capabilities to execute all we set out to achieve.

Goals:

- Leverage science and technology
- Recruit, retain, and develop personnel
- Patient / provider focused information systems which enhance capability
- Enhance jointness

EXECUTIVE SUMMARY: KEY FINDINGS FY 2003

Stakeholder Perspective

Beneficiary and Plan Enrollment Trends

- The number of beneficiaries eligible for DoD medical care increased from 8.4 million in FY 2001 to 9.1 million in FY 2003. The increase is largely due to the mobilization of large numbers of Guard / Reserve members and the extension of benefits to their family members. The numbers differ from last year's estimate of 8.7 million beneficiaries (Ref. page 13).
- Because of Base Realignment and Closure (BRAC) actions, and changes in the beneficiary mix over time, there has been a downward trend in the number of beneficiaries living in Military Treatment Facility (MTF) catchment areas (i.e., within about 40 miles of a military hospital). This trend has implications for the proportion of workload performed between direct and purchased care facilities (Ref. page 15).
  - Active duty family members (ADFMs) and retirees and family members under age 65 experienced the largest declines in the number living in catchment areas.
  - The recent call-ups of National Guard and Reserve members have contributed to the total number of beneficiaries living in noncatchment areas. Most Guard / Reserve members already live in noncatchment areas when recalled to active duty and their families continue to live there.
- Over five million beneficiaries, or about 67 percent of the MHS population eligible for TRICARE Prime, were enrolled by the end of FY 2003 (Ref. page 16).
- Almost 75 percent of all MHS eligible beneficiaries used the MHS in FY 2003 (6.7 million users of 9.1 eligible) (Ref. page 17).

Financial Perspective

Unified Medical Program Funding Trends

- The Unified Medical Program (UMP) increased from $17.5 billion in FY 2000 to $26.3 in FY 2003 and is programmed to increase to $29.3 billion in FY 2004 (est.). FY 2003 and FY 2004 include the DoD Medicare-Eligible Retiree Health Care Fund, known as the "Accrual Fund" (Ref. page 19).
  - UMP expenditures rose from 6.2 percent of DoD Total Obligation Authority (TOA) in FY 2001 to 7.0 percent in FY 2003, and is expected to increase to 7.1 percent of DoD TOA in FY 2004. The increase is due in part to the TRICARE for Life (TFL) benefit, which provides Medicare wrap-around coverage for beneficiaries (Ref. page 19).
- With the exception of the increase in UMP expenditures between FY 2001 and FY 2002 (the year prior to establishing the TFL accrual fund), the rate of growth in UMP expenditures has been stable since FY 2001.
  - Changes in UMP expenditures are comparable to changes in National Health Expenditures between FY 2000 and estimates for FY 2004, which increased between 7 and 9 percent per year during this period (Ref. page 20).

MHS Workload Trends and Impact of New Benefits in FY 2003

- Overall MHS workload increased for all major components of care between FY 2001 and FY 2003: inpatient care (dispositions by 9 percent and bed days 7 percent), outpatient visits (8 percent), and prescription drugs (5 percent, excluding the very large effect of TRICARE Senior Pharmacy (TSRx) discussed below) (Ref. pages 21–22).
  - These increases, for the most part, are attributable to increased purchased care workload and, in the case of prescription drugs, the TSRx benefit. Direct care inpatient workload has declined somewhat (a decline of 2 percent in dispositions and 3 percent in bed days; and prescription drugs by 4 percent), with no change in outpatient workload.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2003 *(CONT'D)*

- Most DoD Medicare-eligible beneficiaries have already taken advantage of the new TFL and TSRx benefits, with 78 percent filing health care claims and 63 percent filing a claim for prescriptions (Ref. page 24).
- Prescription drugs (direct and purchased care) accounted for almost half (49 percent) of the nearly $4 billion in TFL / TSRx expenditures in FY 2003 (Ref. page 25).

External Customer Perspective

Overall Customer Satisfaction With TRICARE

- MHS beneficiary satisfaction with the overall TRICARE plan, as well as with health care, one's personal physician, and specialty care are improving over time, but still lag the civilian benchmarks (Ref. page 27).
  - In 2003, MHS beneficiaries enrolled with civilian network providers reported the same level of satisfaction as the civilian benchmark (Ref. page 28).
  - Satisfaction with TRICARE overall increased for all beneficiary groups in 2003, and, for retirees, their reported satisfaction was comparable to the civilian benchmark (Ref. page 29).

Building Healthy Communities: Meeting Healthy People Goals

- The MHS has improved in several key areas relative to meeting Healthy People (HP) goals, and strives to improve in others. The MHS rate of tobacco use improved by declining to slightly over 17 percent compared to the original HP 2000 goal of 15 percent and revised HP 2010 goal of 12 percent (Ref. page 30).
- The MHS rate of teenage pregnancy (8.1 per 1,000 teenage girls) continues to be better than the HP 2010 goal of 43 per 1,000 (Ref. page 30).

Meeting Preventive Care Standards

- The MHS meets or exceeds national goals for preventive care in providing mammograms (for both 40–50 year old and 50+ categories) and testing for cholesterol. Efforts continue toward achieving HP 2010 standards for pap smears, prenatal exams, blood pressure screening and flu shots (for people age 65 and above). Still other areas continue to be monitored in the absence of specified HP standards, such as breast exams (for 40+ year olds), smoking cessation counseling and prostate exams (Ref. page 31).

Special Study: Reserve Family Member Satisfaction

- There were no statistically significant differences in the satisfaction ratings of Reservist and ADFMs in any of eight areas surveyed in 2001 (satisfaction with: health plan, doctor, specialty care, getting needed care, getting care quickly, customer service, and claims handling). In 2002, a higher proportion of Reservist family members reported they were satisfied with their overall health care compared to ADFMs with no difference in the other seven areas considered (Ref. page 32).

Readiness Perspective

- While the overall MHS rate of dental readiness for Classes 1 and 2 has generally increased since the metric was established, and remains high at about 92 percent, the target rate of 95 percent has not yet been achieved (Ref. page 33).
- TRICARE supported the Global War on Terrorism shortly after the September 11, 2001 attacks through the TRICARE Reserve Family Demonstration Project (TRFDP). This program waived certain administrative and financial requirements to facilitate access to TRICARE for family members of mobilized Reservists. As a result of the over 253,000 mobilized reservists, 432,000 family members were eligible for the TRFDP benefit during this period of time (Ref. page 34).
  - During this time, a total of $143M was spent for purchased care services for these family members: DoD paid about $114M (79 percent), patients paid $8M (6 percent) and patients' other insurance paid $21M (15 percent). The DoD

waived almost $10M in patient cost shares specifically authorized by the Demonstration (Ref. page 34).

Quality

Access To Care

- **Overall Access.** Access to and use of outpatient services remains high, with Prime enrollees reporting they had at least one outpatient visit during the year, increasing between FY 2002 and FY 2003 and almost comparable in 2003 to their civilian counterparts enrolled in managed care plans (Ref. page 35).
- **Availability and Ease of Obtaining Care.** MHS beneficiary ratings improved between FY 2001 and FY 2003 in terms of "getting necessary care, " "waiting for a routine appointment," and "waiting less than 15 minutes to see a doctor." MHS beneficiaries reported wait times to see the doctor at the same level as the civilian benchmark (Ref. page 37).
- **Obtaining a Provider of Choice.** The majority (62 percent) of MHS beneficiaries report they are able to obtain a provider of choice, a level close to the civilian benchmark (Ref. page 38).
- **Customer Service.** MHS beneficiaries report an increasing level of satisfaction with customer service responsiveness, ease of understanding written materials, and dealing with paperwork. The MHS levels lag behind the civilian benchmark (Ref. page 39).
- **Direct Care Appointment Access.** The MHS met its goal of 82 percent of patients reporting satisfaction with making MTF appointments by telephone in FY 2003 (Ref page 40).
- **Preventable Admissions.** The overall rate of preventable admissions (per 1,000 beneficiaries) for all MHS Enrollees remained the same over the three-year period between FY 2001 and FY 2003. The preventable admission rate for active duty personnel increased from FY 2001 to FY 2003 (from 1.8 to 2.1 per 1,000 members) (Ref. page 41).

Efficiencies

Agency Interoperability

- While the total number of sharing Agreements (i.e., Memos of Understanding, contracts, etc.) between DoD and VA facilities increased 3 percent from FY 2001 to FY 2002, the number of arrangements (i.e., shared services or areas of collaboration, such as clinical services; nursing education; telemedicine; informatics; etc.) decreased by almost 18 percent (Ref. page 43).

Support Contract Management

- With respect to contract efficiency, administrative expenses related to contract management have declined from 19.4 percent of total contract revenue to 15.1 percent in FY 2003. The overall estimated expenses incurred by DoD for health services and contracts increased by 36 percent, from $4.2M to $5.8M in FY 2003 (Ref. page 44).

MTF Market Share Trends

- The percentage of both inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas has declined (from FY 2001 to FY 2003) by 3 percent for inpatient and 6 percent for outpatient workload (Ref. page 45).

Claims Processing

- Beneficiary satisfaction with TRICARE claims processing is improving over time. Most MHS beneficiaries reported claims were processed properly (84 percent) and in a reasonable period of time (80 percent). The level reported as in a reasonable period of time was comparable to the civilian benchmark (Ref. page 46).
- The percentage of claims processed within 30 days (99.9 percent in FY 2003) has exceeded the TRICARE goal of 95 percent for the past three years, even as the number of non-TFL claims has increased substantially (Ref. page 47).
- The percentage of all claims filed electronically (excluding TFL claims which are likely to be electronic as well) increased to over 55 percent by the end of FY 2003. Electronic filing has increased in all categories of claims (e.g., professional, institutional, and pharmacy), but pharmacy continues to dominate, with almost

97 percent filed electronically (Ref. page 48).

Health Care Services Utilization

- Utilization of inpatient, outpatient and prescription services was about 50 percent higher for Prime vs. civilian HMO enrollees in FY 2003 (Ref. pages 49, 55 and 59).
- Utilization was higher for TRICARE Standard / Extra vs. civilian PPO users in FY 2003 for prescriptions (24 percent) and inpatient stays (36 percent); however, TRICARE Standard / Extra users had fewer outpatient visits (27 percent) (Ref. pages 60, 50 and 56).

Beneficiary Family Out-of-Pocket Costs

- TRICARE beneficiaries have much lower out-of-pocket costs than civilian counterparts.
  - For younger family members (under 65 years of age), costs were $2,400 to $3,000 less than their civilian counterparts in FY 2003. This difference is largely due to the insurance premium costs incurred by civilians (Ref. page 63).
  - For Medicare- eligible MHS beneficiaries in FY 2003, costs were $2,200 less than their civilian counterparts. The lower costs were due to the new TFL and TSRx benefits programs, which reduced their drug expenses and Medicare supplemental insurance (Ref. page 66).
  - The total cost (i.e., all sources of payment combined) per participant in FY 2003 was 7 percent higher under TRICARE compared with self-insured health plans sponsored by large civilian employers (Ref. page 82).
    - – Although MHS costs are higher, overall utilization (by Prime and non-Prime users combined) of inpatient, outpatient, and prescription services is also higher.
    - – The cost of readiness, which cannot easily be separated from the cost of the peacetime health care benefit, is included in total MHS costs (Ref. page 67).

Learning & Growth

- The TRICARE Online metric is one of several measures recently developed to assess the ability of MHS staff and support systems to provide the capabilities necessary to effectively execute mission requirements. The first year's experience reflects an emerging and maturing system with over 80,000 registered users who made almost 18,000 appointments (Ref. page 69).

WHAT IS TRICARE?

TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health care for all eligible personnel. TRICARE brings together the world-wide health care resources of the Army, Navy, and Air Force (often referred to as "direct care") and supplements this capability with networks of civilian health care professionals (referred to as "purchased care") to provide better access and high quality service while maintaining the capability to support military operations. This health care program for active duty and retired members of the uniformed services, their families, and survivors was originally modeled on Health Maintenance Organization (HMO) plans offered in the private sector and similar DoD health-insurance programs. In addition to receiving care from military treatment facilities, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the traditional indemnity benefit (also known as fee-for-service, or FFS), formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except active duty service members (and, until recently, Medicare-eligibles). No enrollment is required to obtain care from civilian providers. This option requires payment of an annual deductible (individual or family) and cost-sharing. TRICARE became second payer to Medicare in FY 2002 for Medicare-eligible military retirees and their family members.
- **TRICARE Extra** is based on a Preferred Provider Organization (PPO) model in which beneficiaries eligible for TRICARE Standard may decide to use preferred civilian network providers on a case-by-case basis (i.e., they may switch between the Standard and Extra benefit). Like Standard, no enrollment is required but, by using network providers, beneficiaries reduce their cost sharing by 5 percent. Under Extra, authorized contracted providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like plan in which beneficiaries enroll in this benefit option where it is offered. Each enrollee chooses or is assigned a Primary Care Manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations) and arranging for specialty provider services as appropriate. Prime offers enrollees additional benefits such as access standards in terms of maximum allowable waiting times to obtain an appointment, emergency services (24 hours per day, 7 days per week), and waiting times in doctors' offices; as well as preventive and wellness services (e.g., routine eye exams, immunizations, hearing tests, mammograms, Pap tests, prostate examinations). A point-of-service (POS) option permits enrollees to seek care from non-network providers, but with significantly higher cost sharing than under Standard.

NEW BENEFITS AND PROGRAMS IN FY 2003

TRICARE continues to evolve, offering new programs, refining and enhancing existing benefits and programs, and improving the overall efficiency and effectiveness of this Tri-Service health care organization. New benefits and programs implemented in FY 2003 or scheduled to be implemented shortly thereafter include:

- **TRICARE Prime Remote for Active Duty Family Members (TPRADFM).** TPRADFM is a new benefit introduced in September 2002 that mirrors the TRICARE Prime Remote (TPR) benefit already in place for active duty service members. TPR/TPRADFM provides a Prime-like benefit for Uniformed Service members and their families who are on remote assignment, typically at least 50 miles from an MTF. TPR and TPRADFM are offered in the 50 United States only, and both require enrollment. Family members who choose to enroll may receive health care from either a TRICARE network provider or, if a network provider is not available, from any TRICARE-authorized civilian provider. Active duty family members who choose not to enroll may continue using the TRICARE Standard or Extra benefits, with applicable cost shares and deductibles.

  Although a new benefit, TPRADFM will likely have little impact on the utilization and cost statistics presented in this report since an interim measure eliminating cost shares and deductibles for ADFMs who accompany their sponsors on assignment to a remote location had been in effect since October 2000.

- **Health Care for Families of Reserve Component Members.** Reserve component personnel who are called to active duty for more than 30 days are eligible for TRICARE, the same as any active duty service member. Families of these individuals are eligible for TRICARE if the sponsor is called to active duty for more than 30 days. This past year, DoD announced a new policy to enhance access to health care for National Guard and Reserve members. Effective March 10, 2003, family members of National Guard and Reserve members activated to military service for more than 30 days may now enroll in TRICARE Prime (reduced from 179 days). This benefit has no deductibles, copayments or claim forms for family members to file. Family members who reside with their sponsors in a TPR location at the time of the sponsor's activation may now enroll in the TPRADFM program.

- **Elimination of Nonavailability Statements.** Prior to the implementationof TRICARE, beneficiaries living within a catchment area were required to obtain a Nonavailability Statement (NAS) from the local MTF before they could obtain reimbursable inpatient or outpatient care from civilian sources. The NAS is a certification, issued by the MTF, that a specific medical service is not available to the beneficiary at the time the beneficiary seeks the service. Congress has gradually reduced the NAS requirements since 1997, such that, by December 31, 2003, all requirements willbe eliminated except for MTF authorityto issue NASs for inpatient mental health services. Thus beneficiaries will now have near complete flexibility in choosing whether to receive care from military or civilian sources. We can clearly expect this to have an impact on both direct and purchased care utilization and costs beginning in FY 2004.

  - Section 734 of the National Defense Authorization Act for Fiscal Year 1997 (NDAA-97) eliminated the authority of the military Departments to require beneficiaries to obtain NASs for outpatient services reimbursed under TRICARE/CHAMPUS. Additionally, the NDAA-97 eliminated the authority to require NASs for beneficiaries enrolled in TRICARE Prime. An exception was made for maternity patients who live in an MTF's catchment area who were not enrolled in Prime. TRICARE requires that, except for emergencies, these patients get all of their maternity care—both inpatient and outpatient—from that MTF unless they have other health insurance.

  - Section 728 of NDAA-01 eliminated the requirement for prior authorization before referral to a network specialty provider.

NEW BENEFITS AND PROGRAMS IN FY 2003 *(CONT'D)*

- Section 735 of NDAA-02 eliminated the requirement for non-enrolled TRICARE beneficiaries to obtain an NAS before receiving nonemergent inpatient or obstetrical (inpatient or outpatient) services from civilian providers. Section 735 retains MTF NAS authority for inpatient mental health services within the 40-mile MTF catchment area. This section also eliminated the national NAS requirement for specialized treatment services (STSs) for TRICARE Standard beneficiaries residing outside the 200-mile radius of a designated STS facility.

➤ **TRICARE Next Generation of Contracts.** The TRICARE Management Activity (TMA) is replacing its regional managed care support service contracts, and other medical and dental contracts that are about to expire, with the next generation of TRICARE contracts. Under this next generation of contracts, TMA will include incentives for the health services and support contractors with respect to superior and measurable performance in customer service, quality of care and access to care.

The current seven contracts covering 11 regions will be replaced by three contracts covering three consolidated regions. This consolidation is intended to improve portability and reduce the administrative costs of negotiating change orders and providing DoD oversight across seven contracts. Additionally, the reduction in the number of contracts should improve TMA's responsiveness and allow for a uniform implementation period. The three regional contracts will each have Integrated Health Care Delivery and Administrative Services requirements to include network functions, health care functions, claims processing, enrollment, provider certification and related administrative services. TMA is working out the details of a regional governance infrastructure that will provide support for geographic areas with a high concentration of DoD beneficiaries.

Key objectives defined in the new regional contracts include:

- Optimization of the delivery of health care services in the direct care system for all MHS beneficiaries (active duty personnel, MTF enrollees, civilian network enrollees, and nonenrollees).
- Achievement of beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services.
- Attainment of "best value health care" services in support of the MHS mission utilizing commercial practices when practical.

The new regional contracts include strong financial incentives for excellent performance, including:

- Clear incentives for maximizing referrals into MTFs.
- Establishment of an incentive award fee pool to be administered by the TRICARE Regional Director.
- Performance on an extensive list of specific, measurable items such as claims processing timeliness, network adequacy, and telephone responsiveness.

The new contract structure carves out certain elements so that contractors may focus on their core competencies. The carve-out elements include:

- The TRICARE Dual Eligible Fiscal Intermediary Contract: This contract is designed to perform claims processing and customer service functions for DoD beneficiaries who also are eligible for Medicare. For most claims filed by this clearly defined population, TRICARE is second payer to Medicare.
- Pharmacy services are available to beneficiaries through one of three venues: MTFs, the TRICARE Mail Order Program (TMOP) and contracted retail pharmacies.
  - The TMOP benefit contract replaced a previous national mail order pharmacy contract. In September 2003, the ASD(HA) announced award of the TRICARE Retail Pharmacy contract for a Pharmacy Benefit Manager (PBM) to provide a nationwide network of retail pharmacies to fill

NEW BENEFITS AND PROGRAMS IN FY 2003 *(CONT'D)*

prescriptions for TRICARE beneficiaries in the 50 United States, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands

  - The national retail pharmacy services contract is designed to integrate the various retail pharmacy programs currently available. With this contract, TMA seeks to solve many beneficiary portability issues, reduce administrative costs, and provide a consistent benefit. The new retail pharmacy program will be fully portable, allowing beneficiaries access to network pharmacies while traveling outside of their regions. The single contract will better serve TRICARE beneficiaries, be simpler for DoD to administer, and make the program more accountable. The transition to the new retail pharmacy contract began on October 1, 2003, and will continue through the next six months; the turnover of responsibility for delivery of retail pharmacy services will occur nationwide on April 1, 2004.

- Marketing/Education Contract: TMA is developing a separate contract to create a national suite of TRICARE Marketing and Education products that will provide a uniform message and reinforce the fact that TRICARE is a single, portable benefit.
- Local Support Contracts: MTF commanders will be able to contract for services beyond the national contracts. A Local Support Contracts team will create task order vehicles for appointing and scheduling support.

➤ **TRICARE For Life (TFL) and TRICARE Senior Pharmacy (TSRx).** Finally, two key programs for Medicare-eligible beneficiaries begun in FY 2002 reached maturity in FY 2003, with initial results presented in last year's report. By way of background, when DoD beneficiaries become eligible for Medicare Part A, they can use TFL, provided they purchase Medicare Part B (begun October 1, 2001). Although these beneficiaries are not eligible for TRICARE Prime, they are eligible to use Medicare, network, and non-network providers. Under TFL, TRICARE acts as second payer to Medicare for benefits payable by both Medicare and TRICARE. Beneficiaries can use an authorized Medicare provider and claims will be automatically sent to TRICARE after Medicare pays its portion. There are no enrollment fees for TFL. Beneficiaries are only required to pay the Medicare Part B premium. TRICARE is first payer for TRICARE benefits not covered by Medicare, such as outpatient prescription drugs (via the TSRx program, which began April 1, 2001). TSRx offers access to a complete pharmacy benefit provided through either direct care military facilities or purchased care civilian facilities, including contracted network pharmacies and a national mail order program.

REPORT APPROACH AND SCOPE

This report continues to take the approach used in last year's report of comparing TRICARE with civilian-sector benchmarks (where available), extending the trends to cover an additional year of data. Until the FY 2002 *Report to Congress*, all previous TRICARE evaluations took the approach of comparing TRICARE in the evaluation year with the traditional benefit of direct care and CHAMPUS in FY 1994 adjusted for known, measurable changes that would likely have occurred even in the absence of TRICARE. Because the FY 1994 baseline is too far removed from present-day TRICARE experience, the FY 2002 report changed the focus of the evaluation from a "before and after" comparison to a look at recent trends in access, quality, utilization, and costs. This report summarizes nationwide trends under TRICARE, and, unless otherwise noted, compares the U.S. regions of TRICARE with comparable U.S. civilian-sector benchmarks. The 11 non-overseas regions are: 1 (Northeast), 2 (Mid-Atlantic), 3 (Southeast), 4 (Gulf South), 5 (Heartland), 6 (Southwest), 7/8 (TRICARE Central), 9 (Southern California), 10 (Golden Gate), 11 (Northwest), and 12 (Hawaii).

TRICARE WORLDWIDE PROGRAM OPERATIONS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2004

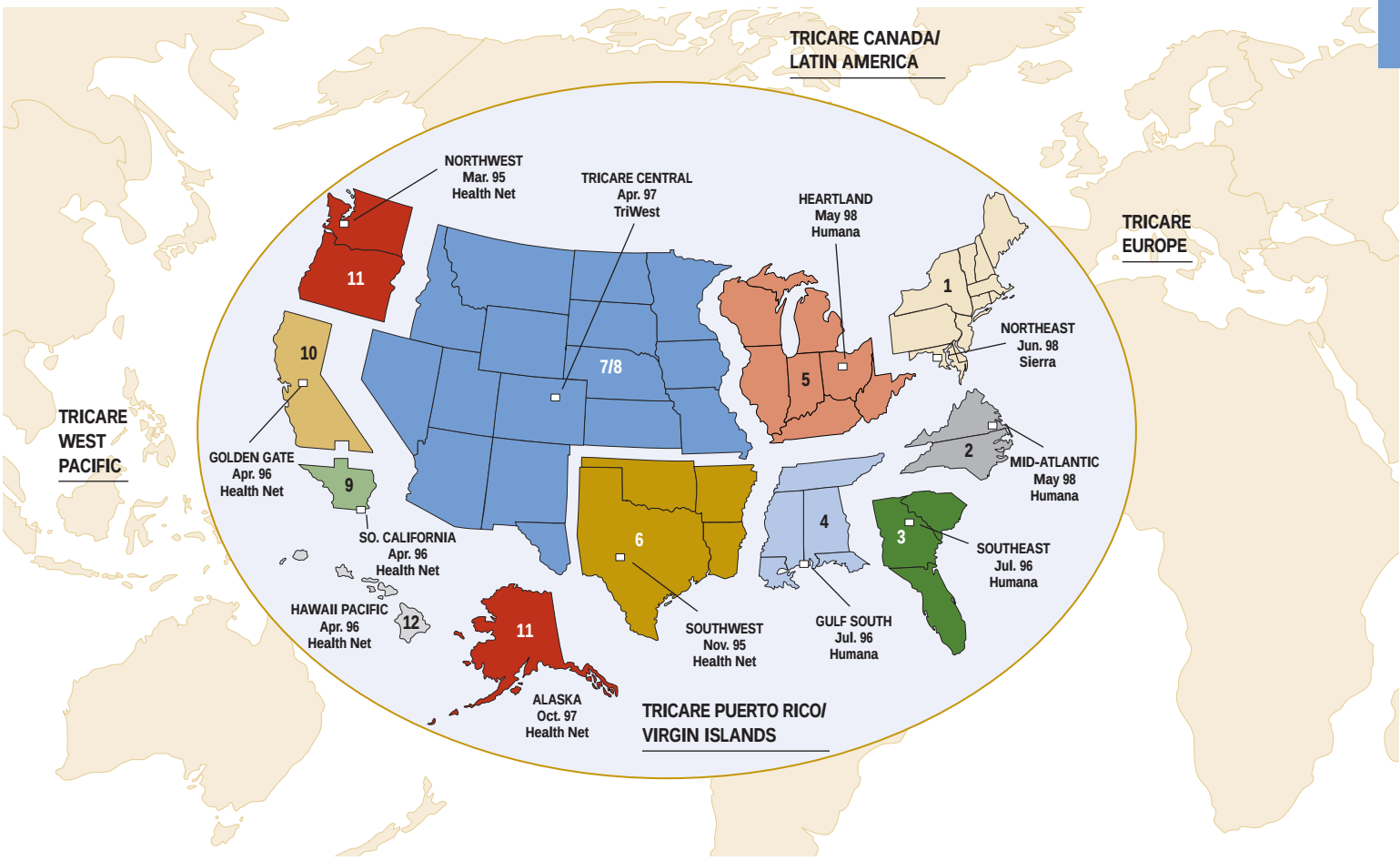
Total Beneficiaries	8.9 million
Prime Enrollees	5.1 million
Military Hospitals & Medical Centers	75
Medical Clinics	461
Total Military Health System Personnel	132,565
Total Unified Medical Program (UMP):	$29.3 billion*
Estimated FY 2004 Receipts	$4.9 billion**

* Includes direct care and private sector care funding, Military Personnel, and military construction.

**The DoD Medicare Eligible Retiree Health Care Fund, implemented in fiscal year 2003, is an accrual fund that pays for health care provided to Medicare-eligible beneficiaries, including payment for the TRICARE for Life benefit first implemented in fiscal year 2002.

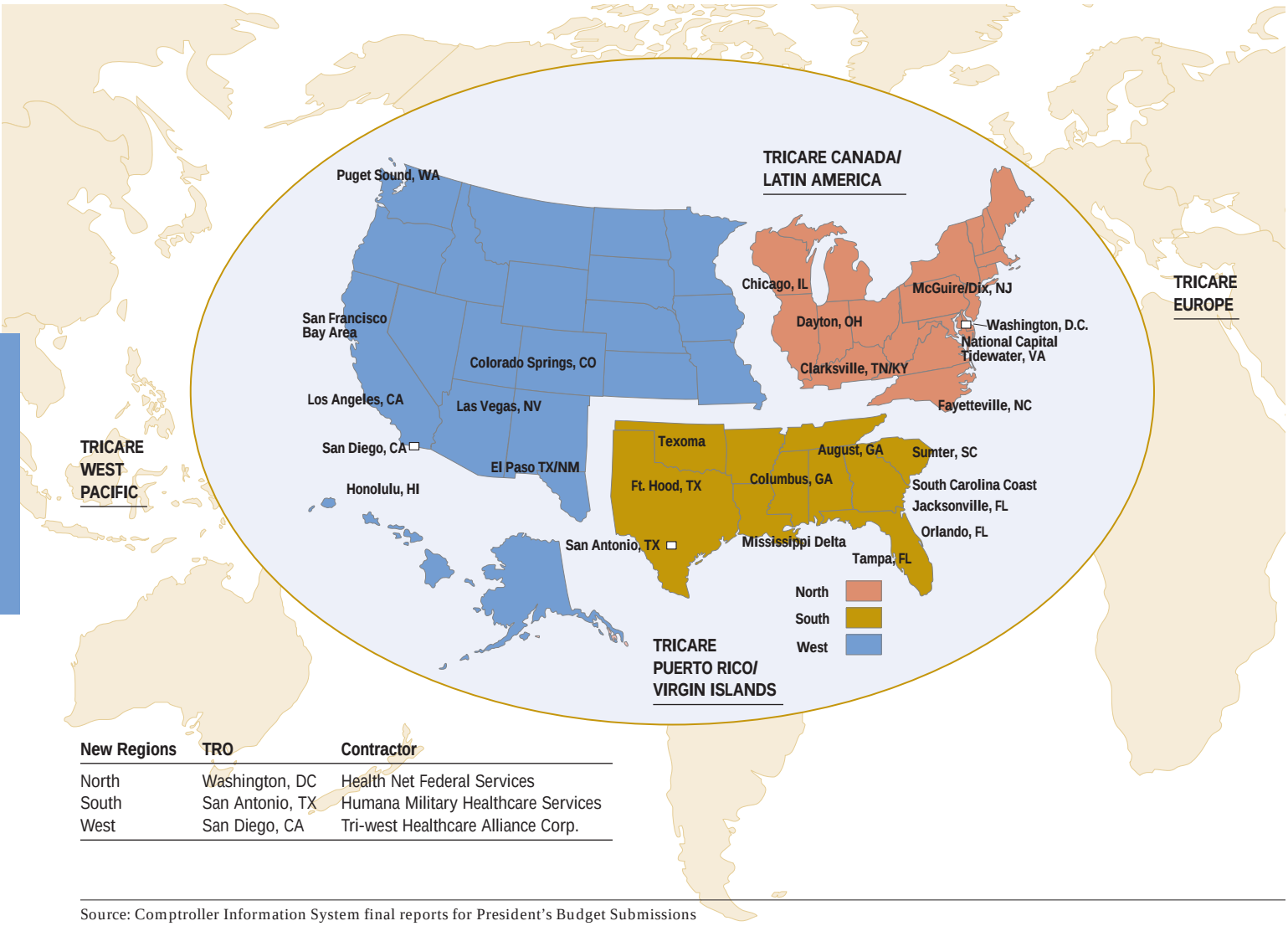
TRICARE is administered on a regional basis. Excluding overseas programs, the country is currently divided into 11 geographical health services regions since the beginning of TRICARE (Regions 1–12, where 7/8 is a combined region) with a senior military officer designated as the Lead Agent for each region), as reflected in the map below. Regional Lead Agents and their support staff help coordinate primary and referral direct and purchased care within their regions.

TRICARE HEALTH SERVICE REGIONS, LEAD AGENTS, OPERATIONAL START DATES, AND CONTRACTORS



However, as noted earlier, over the next year the TRICARE regions will be consolidated, as the next generation of TRICARE contracts will result in three health service regions, each supported by a TRICARE Regional Office (TRO) and health care support contractor, as depicted below.

NEW TRICARE REGIONAL STRUCTURE



New Regions	TRO	Contractor
North	Washington, DC	Health Net Federal Services
South	San Antonio, TX	Humana Military Healthcare Services
West	San Diego, CA	Tri-west Healthcare Alliance Corp.

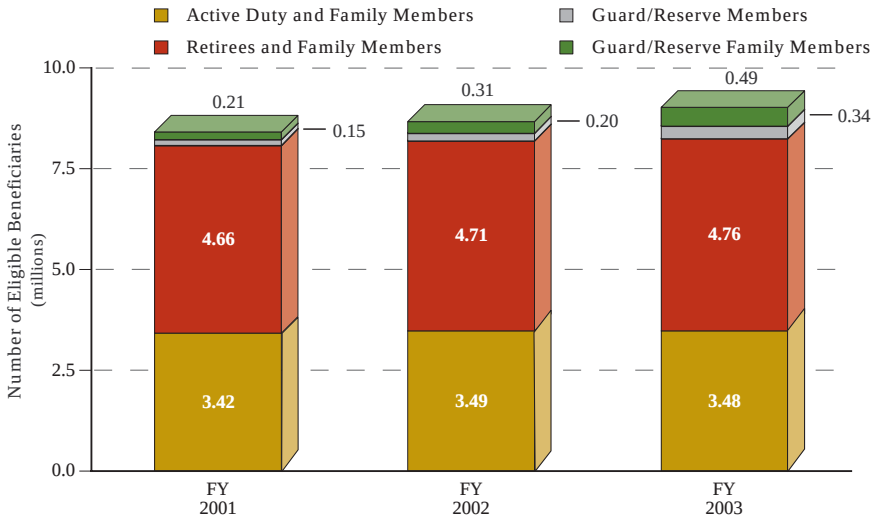
Source: Comptroller Information System final reports for President's Budget Submissions

BENEFICIARY TRENDS AND DEMOGRAPHICS

Trend in the Number of Eligible Beneficiaries Between FY 2001 and FY 2003

The number of beneficiaries eligible for DoD medical care increased from 8.4 million in FY 2001 to 9.1 million in FY 2003. The increase is largely due to the mobilization of large numbers of Guard / Reserve members and the extension of benefits to their family members. The number differs from last year's estimate of 8.7 million beneficiaries.

TRENDS IN THE NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS)

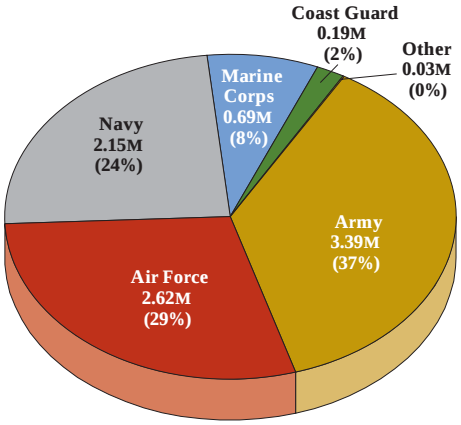
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2003

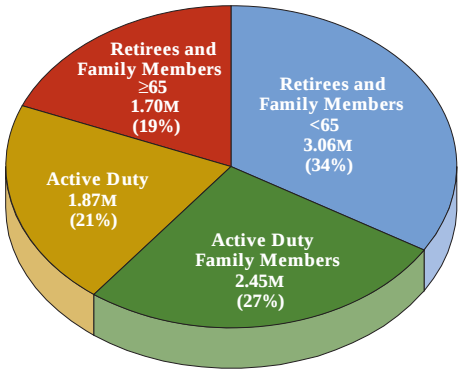
The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, National Oceanic and Atmospheric Administration).

Whereas active duty personnel (including Guard / Reserve component members on active duty for at least 30 days) and their family members comprise 47 percent of the eligible population (21 percent and 27 percent, respectively), retirees and their family members comprise the largest component, with 53 percent (34 percent under age 65 and 19 percent age 65 and over, respectively).

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS IN FY 2003



Service Branch



Beneficiary Category

Source: DEERS

Note: Percentages may not add to 100% due to rounding.

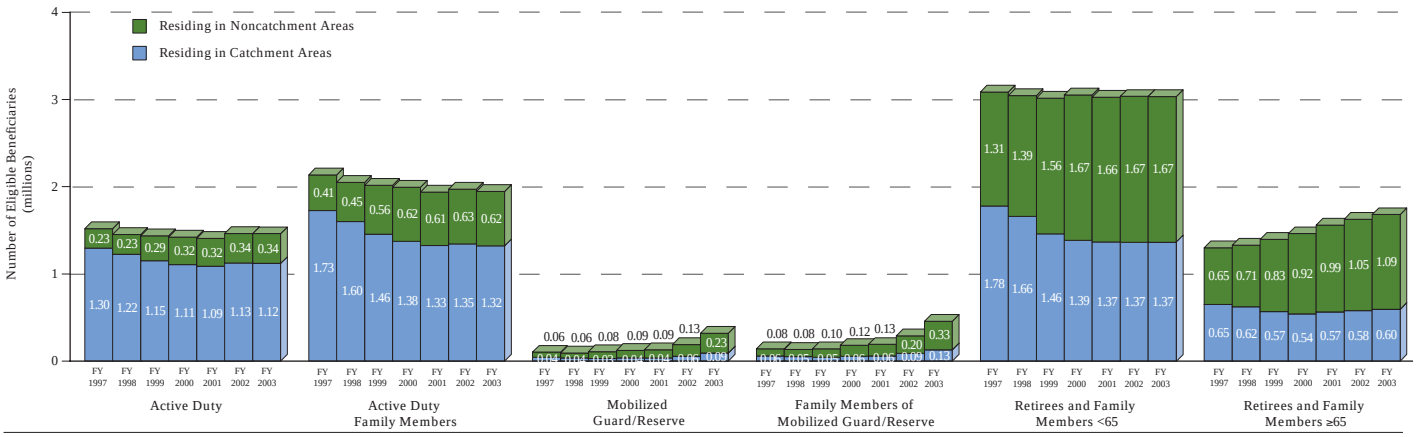
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries Living in Catchment Areas

A catchment area is defined as the area within approximately 40 miles of a military hospital, allowing for natural geographic boundaries and transportation accessibility. Noncatchment areas lie outside catchment area boundaries. Because of Base Realignment and Closure (BRAC) actions and changes in the beneficiary mix over time, there has been a downward trend in the number of beneficiaries living in catchment areas. This trend has implications for the proportion of workload performed in direct and purchased care facilities.

- Active duty family members and retirees and family members under age 65 experienced the largest declines in the number living in catchment areas.
- The recent call-ups of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when recalled to active duty and their families continue to live there.

TREND IN THE NUMBER OF ELIGIBLE BENEFICIARIES LIVING IN AND OUT OF MTF CATCHMENT AREAS



Source: DEERS

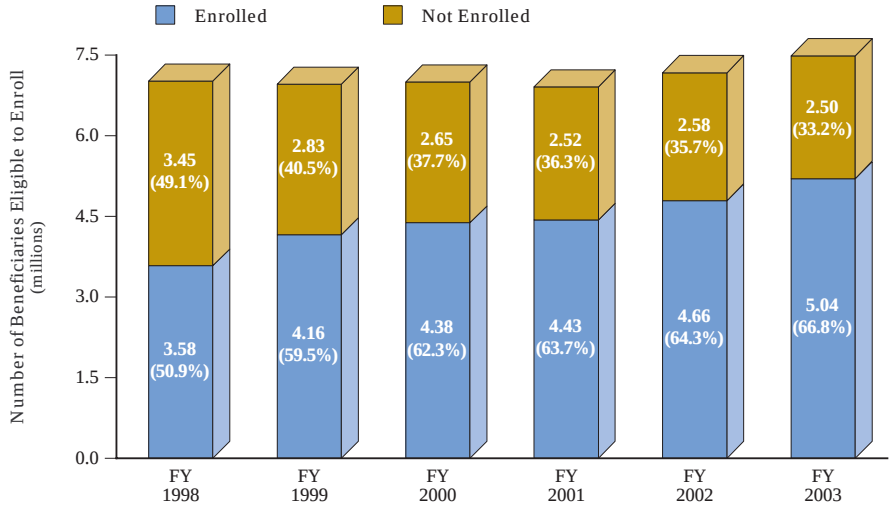
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from the Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this presentation, all active duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and over (some were eligible for TRICARE Senior Prime in FY 2001 and early FY 2002) but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

- TRICARE Prime enrollment, both in raw numbers and as a percentage of those eligible to enroll, has steadily increased since FY 1998, when the last regional Managed Care Support Contracts became fully operational (Regions 1, 2, and 5).
- Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program that is offered at selected MTFs) are excluded from the enrollment counts below; they are included in the nonenrolled counts. The number of beneficiaries enrolled in TRICARE Plus increased from 136,420 at the end of FY 2002 to 155,920 at the end of FY 2003.
- By the end of FY 2003, about 67 percent of all eligible beneficiaries were enrolled in Prime (5.04 million enrolled of the 7.55 million eligible to enroll).

HISTORICAL ENROLLMENT NUMBERS



Source: DEERS

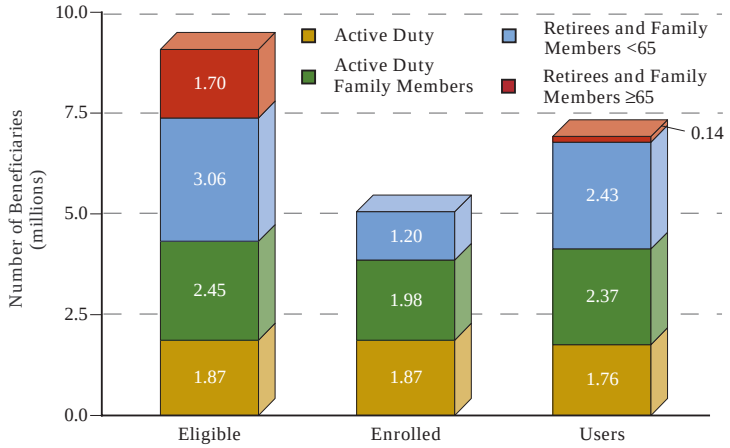
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

FY 2003 Eligibles, Enrollees, and Users

Eligibility for and enrollment in TRICARE Prime by beneficiary category as of the end of FY 2003 were determined from the DEERS. TRICARE Plus enrollees are not included in the enrollment counts. In this section, an MHS user is defined as a beneficiary (whether enrolled or not) who used at least one MHS service (inpatient, outpatient, or prescription) from either a direct or purchased source of care during FY 2003. TFL users are excluded.

- Over 80 percent of ADFMs are enrolled in TRICARE Prime, whereas only about 40 percent of retirees and family members under age 65 are enrolled.
- Almost 75 percent of all MHS-eligible beneficiaries used the MHS in FY 2003 (6.7 million users of 9.1 eligible).
- Although far fewer retirees and family members under age 65 are enrolled, more of them use MHS services than do ADFMs.

NUMBER OF FY 2003 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY

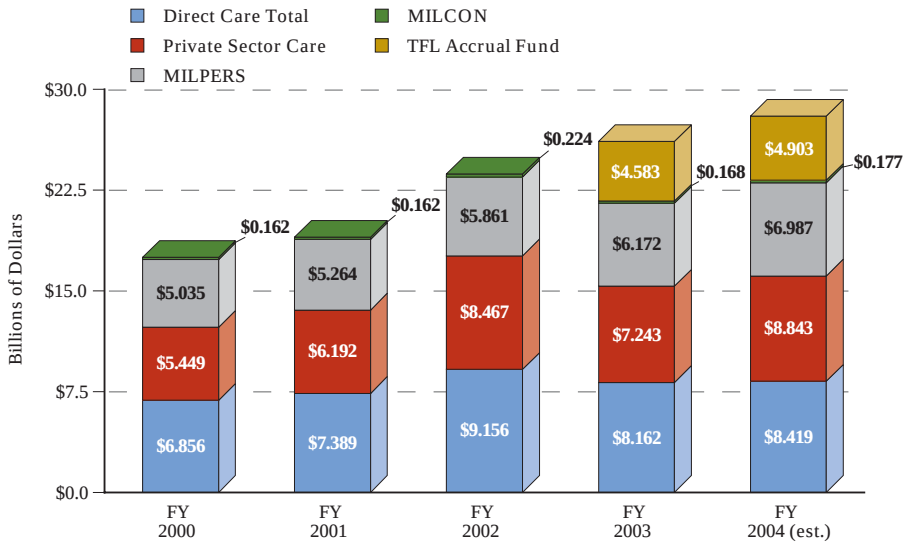


Sources: DEERS and MHS administrative data

UNIFIED MEDICAL PROGRAM FUNDING

The Unified Medical Program (UMP) increased from $17.5 billion in FY 2000 to $26.3 billion spent in FY 2003 and is programmed to rise to $29.3 billion in FY 2004. The FY 2003 and FY 2004 funding include the DoD Medicare-Eligible Retiree Health Care Fund (the "Accrual Fund") for the TRICARE for Life (TFL) benefit, which began in October 2001.

FY 2000 TO FY 2004 (EST.) UNIFIED MEDICAL PROGRAM



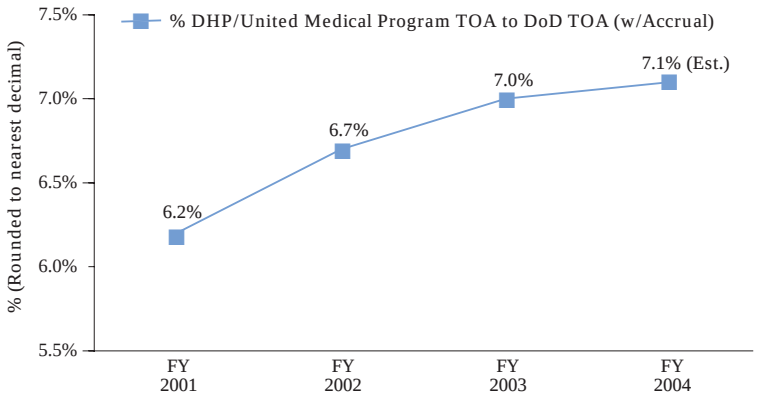
Source: Comptroller Information System final reports for President's Budget Submissions (January 13, 2004)

UMP Share of Defense Budget

Unified Medical Program expenditures rose from 6.2 percent of DoD Total Obligation Authority (TOA) in FY 2001 to 7 percent in FY 2003. The increase is due in part to the TFL benefit, which provides Medicare wrap-around coverage for beneficiaries age 65 and over.

- Expenditures are expected to increase to 7.1 percent of DoD TOA in FY 2004.

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2001–FY 2004 (EST.)

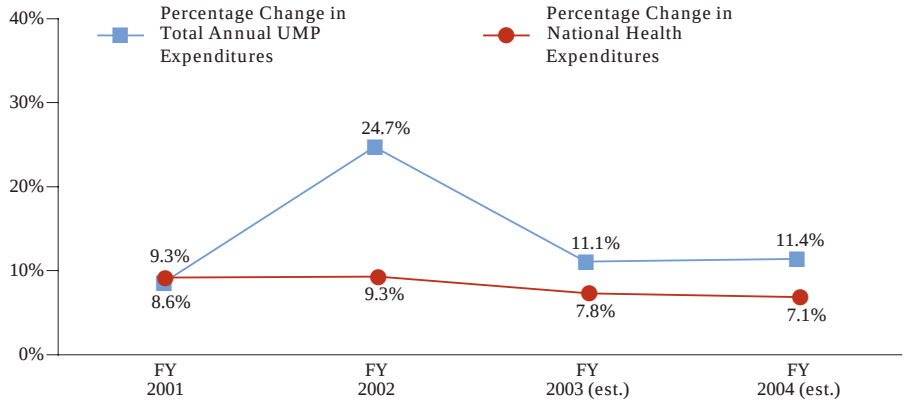


Source: Comptroller Information System final reports for President's Budget Submissions (January 13, 2004)

Comparison of Unified Medical Program and National Health Expenditures over time

With the exception of the increase in UMP expenditures between FY 2001 and FY 2002 (the year prior to establishing the TFL accrual fund), the rate of growth in UMP expenditures has been stable and higher than changes in National Health Expenditures between FY 2001 and estimates for FY 2004.

COMPARISON OF CHANGE IN ANNUAL UNIFIED MEDICAL PROGRAM AND NATIONAL HEALTH EXPENDITURES OVER TIME (FY 2001– FY 2004)



Sources: Unified Medical Program and DHP Expenditures: Comptroller Information System final reports for President's Budget Submissions (percentages from data reflected in the chart on the previous page entitled "FY 2000 to FY 2004 (est.) Unified Medical Program")

National Health Expenditures: Heffler S, Smith S, Keehan S et al. Health Spending Projections through 2013. *Health Affairs*. 2004; 11 Feb:W4-79–W4-93. Actual expenditures (in $Billions): 2000 ($1,310.0), 2001 ($1,424.5), 2002 ($1,553.0), 2003 ($1,673.6 projected), 2004 ($1,793.6 projected).

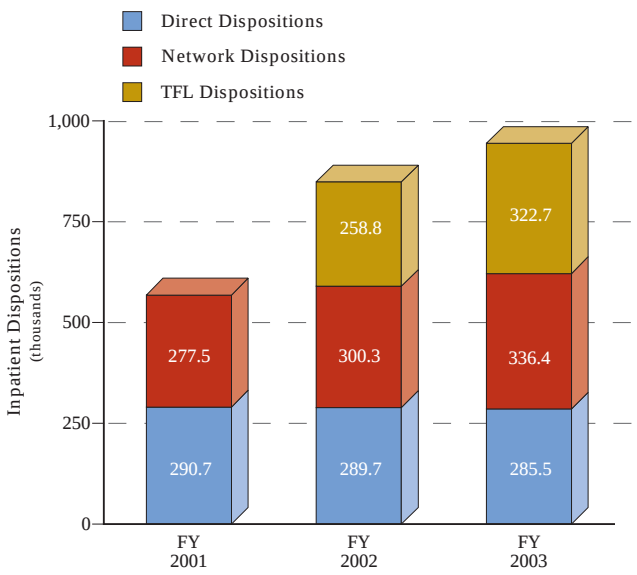
MHS WORKLOAD TRENDS

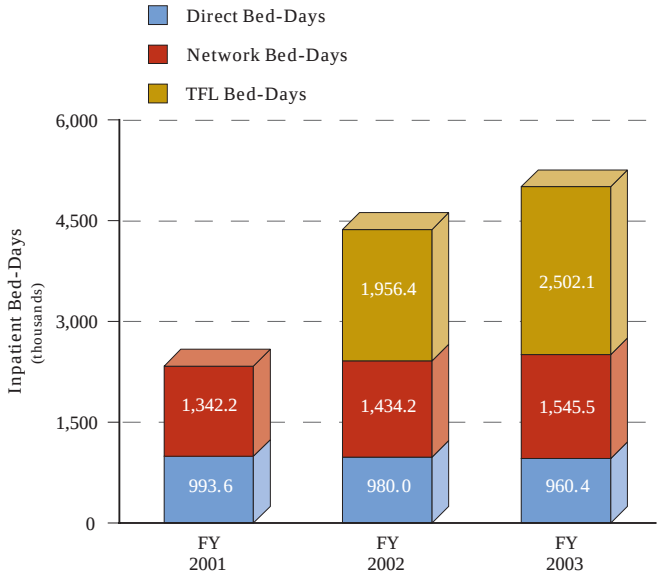
MHS Inpatient Workload

Total MHS inpatient workload (measured as the number of inpatient dispositions or bed-days) increased between FY 2001 and FY 2003 (dispositions increased by 9 percent and bed-days increased by 7 percent), excluding the effect of TFL.

- Direct care inpatient dispositions declined by 2 percent and bed-days declined by 3 percent.
- Purchased care inpatient dispositions increased by 21 percent excluding TFL workload and by 137 percent including TFL.
- Purchased care inpatient bed-days increased by 15 percent excluding TFL workload and by 201 percent including TFL.

TRENDS IN MHS INPATIENT WORKLOAD





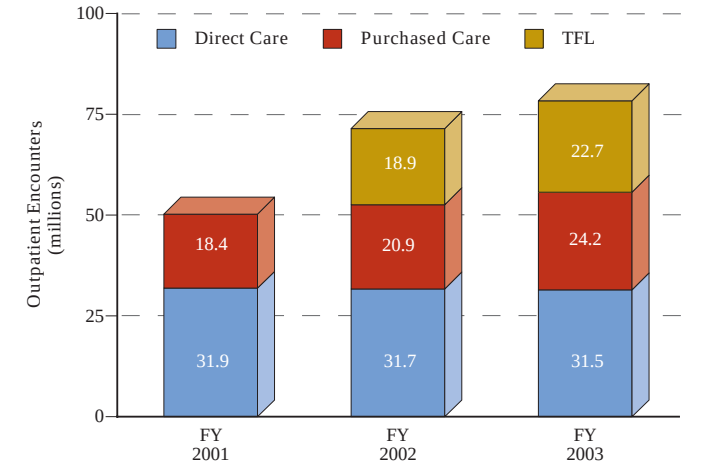
Source: MHS administrative data

MHS WORKLOAD TRENDS *(CONT'D)*

MHS Outpatient Workload

Total MHS outpatient workload (measured as the number of outpatient encounters and ambulatory procedures) increased by 11 percent from FY 2001 to FY 2003, excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



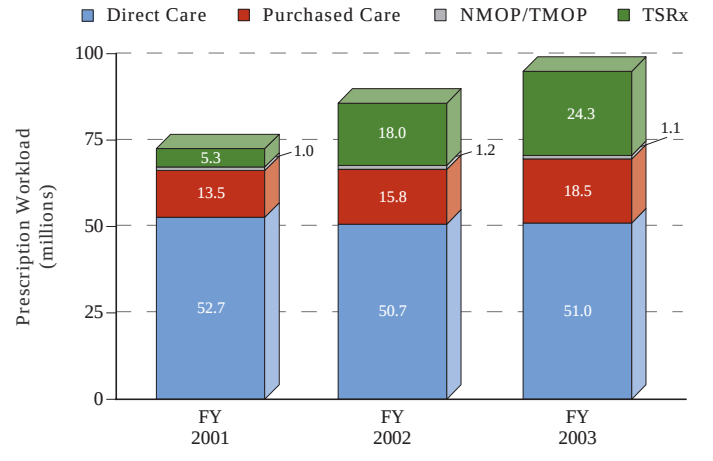
Source: MHS administrative data

- Direct care outpatient workload remained about the same.
- Purchased care outpatient workload increased by 31 percent excluding TFL workload and by 155 percent including TFL.

MHS Prescription Drug Workload

Prescription drugs include all initial and refill prescriptions filled at military pharmacies, network pharmacies, and the TRICARE Mail Order Pharmacy (TMOP, formerly the National Mail Order Pharmacy). Prescription workload is shown as actual prescription counts, unadjusted for differences in the average days supply from these sources.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Note: Prior to TSRx, select groups of Medicare-eligible beneficiaries were authorized access to purchased care prescription drugs if they resided in a location where an MTF was closed due to BRAC, or if they participated in the TRICARE Senior Supplement Demonstration. These benefits were later folded into the TSRx program when it was introduced in April 2001. For ease of presentation, we label all these benefits as TSRx.

Source: MHS administrative data

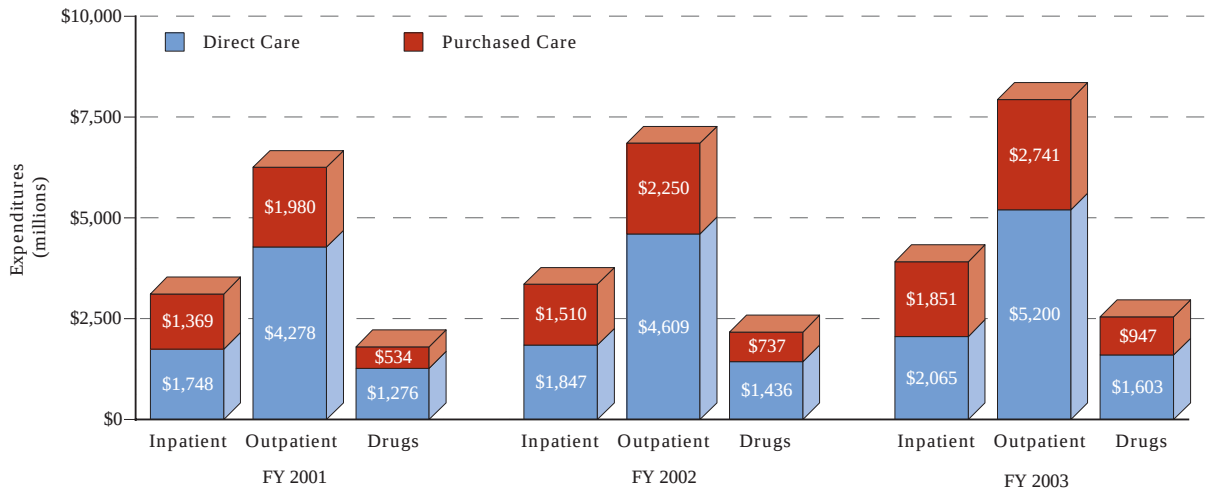
- Total MHS prescription workload increased by 5 percent from FY 2001 to FY 2003, excluding the effect of the TSRx benefit.
- Direct care prescription workload declined by 4 percent in FY 2002 and rebounded slightly in FY 2003.
- Purchased care prescription workload increased each year from FY 2001 to FY 2003 (18 percent in FY 2002 and 17 percent in FY 2003), excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased care prescription workload increased by 77 percent in FY 2002 and by another 28 percent in FY 2003.

MHS COST TRENDS

Total MHS costs have increased between FY 2001 and FY 2003, for all three major components of health care services: inpatient, outpatient and prescription drugs, although the relative proportion remained about the same.

- The share of total DoD expenditures on outpatient care relative to inpatient care (excluding the effects of TFL) remained at about 67 percent from FY 2001 to FY 2003.
- In the interval from FY 2001 to FY 2003, DoD spent an average of about $2 for outpatient care for every $1 spent on inpatient care.
- For inpatient, outpatient, and prescription drug care, the proportion of total expenses for care provided in DoD facilities fell. Overall, the proportion of total expenses for care provided in DoD facilities fell from 65 percent in FY 2001 to 61 percent in FY 2003.

TREND IN DoD EXPENDITURES FOR HEALTH CARE



Note: TFL costs are excluded from the above calculations.

Source: MHS administrative data

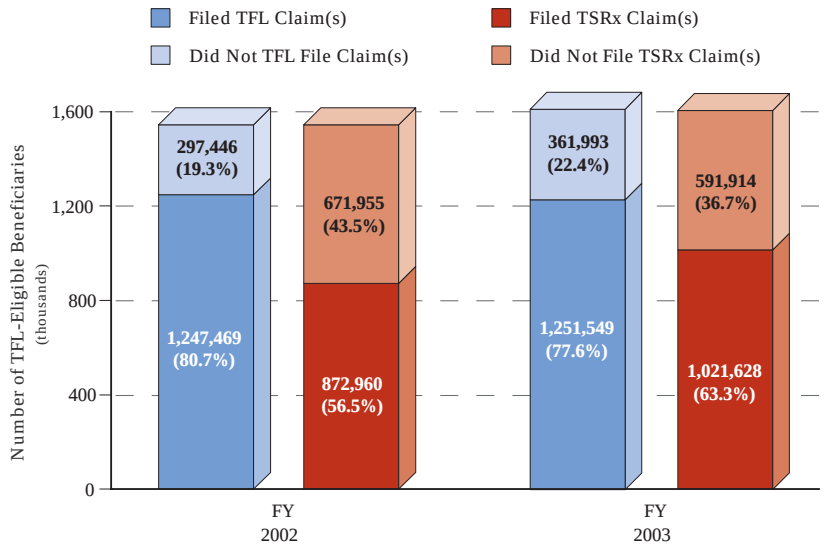
IMPACT OF TRICARE FOR LIFE (TFL) IN FY 2002–2003

The TFL program began October 1, 2001, in accordance with the provisions of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. Under TFL, military retirees aged 65 years and older ("65+") and certain family members enrolled in Medicare Part B, are entitled to TRICARE coverage.

TRICARE for Life and TRICARE Senior Pharmacy Beneficiaries Filing Claims

- There were 1.76 million Medicare-eligible DoD beneficiaries by the end of FY 2003, compared with 1.70 million at the end of FY 2002.
  - At the end of FY 2003, 1.61 million were eligible for the TFL and TSRx benefits, whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage.
- About 78 percent of TFL-eligible beneficiaries filed at least one claim in FY 2003, compared with 81 percent in FY 2002.
  - The reasons some beneficiaries do not file claims are varied, including not receiving any care at all, retaining Medicare supplemental insurance that pays for most costs not covered by Medicare, and maintaining enrollment in a Medicare risk HMO that has small or no enrollment fees and copayments.
- About 63 percent of TFL-eligible beneficiaries filed at least one TSRx claim in FY 2003, compared with 57 percent in FY 2002.

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2002–03



Source: MHS administrative data

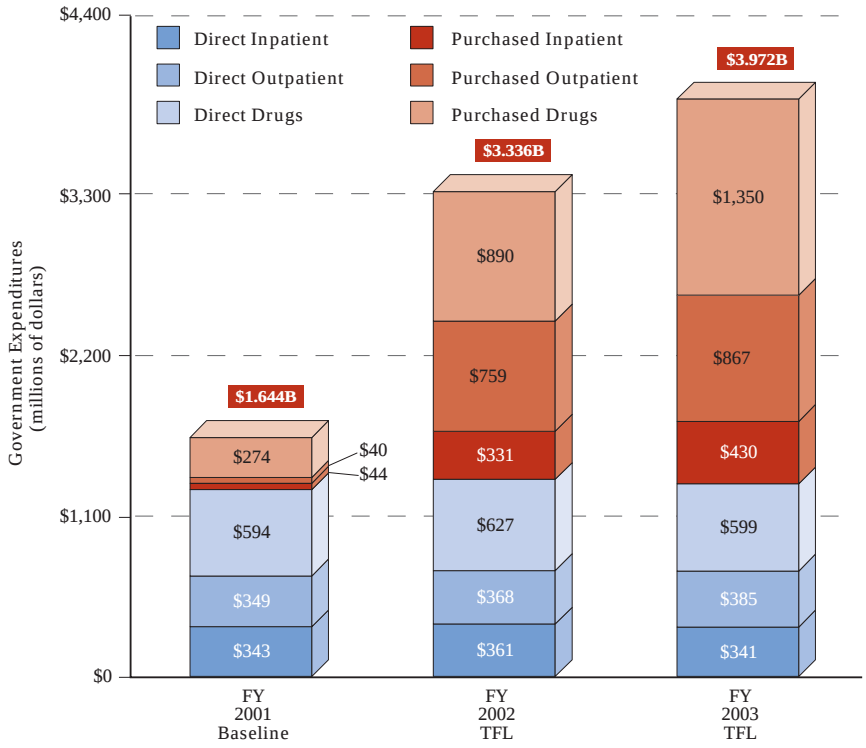
IMPACT OF TRICARE FOR LIFE IN FY 2003 *(CONT'D)*

TRICARE for Life and TRICARE Senior Pharmacy Beneficiaries Expenditures

In order to compare the effect of TFL and TSRx on DoD costs, baseline expenses are defined as those DoD spent for the care of MHS seniors in FY 2001. Most baseline inpatient and outpatient expenses were incurred by beneficiaries enrolled in TRICARE Senior Prime (ended December 2001) and the Uniformed Services Family Health Plan (continues). Most prescription expenses were incurred by beneficiaries using the TSRx program, which began in April 2001.

- TFL has had very little impact on DoD direct care expenses, i.e., total DoD expenditures on behalf of TFL-eligible beneficiaries remained essentially constant from FY 2001 to FY 2003.
  - In FY 2002, TRICARE Plus enrollees accounted for 51 percent of DoD direct care inpatient and outpatient expenditures on behalf of TFL-eligible beneficiaries. The percentage increased to 68 percent in FY 2003.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 36 percent of total DoD direct care expenditures on behalf of TFL-eligible beneficiaries in FY 2002 and for 49 percent in FY 2003.
- Purchased care TFL expenditures increased from FY 2002 to FY 2003 for inpatient, outpatient, and purchased drugs. The most dramatic increase was for purchased drugs, where DoD costs increased by 52 percent.

DoD TFL EXPENDITURES IN FY 2002–03 BY TYPE OF SERVICE



Source: MHS administrative data

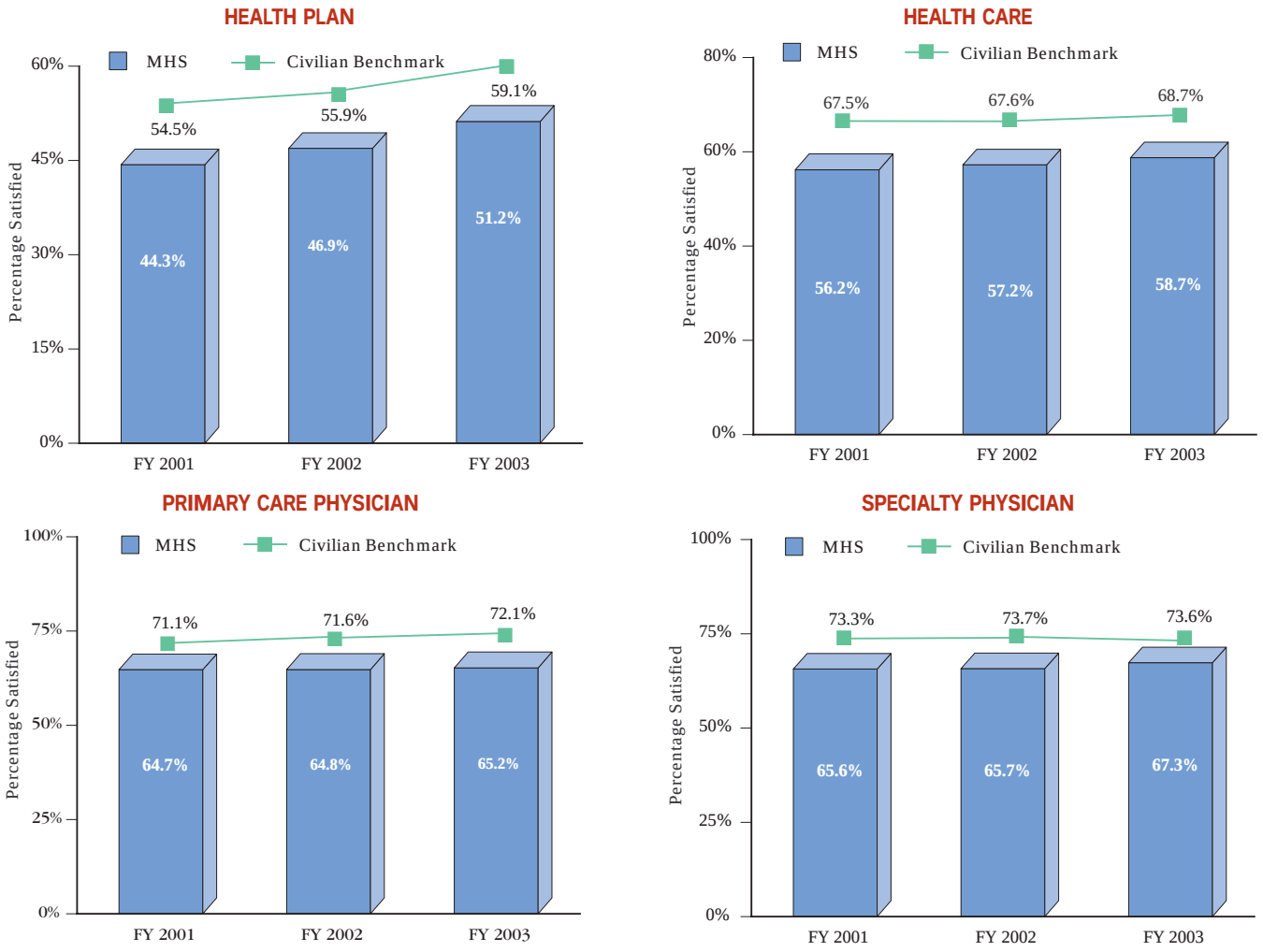
The External Customers theme focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed these standards. The metrics presented here focus on Customer Satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER SATISFACTION WITH KEY ASPECTS OF TRICARE

The health care consumer satisfaction surveys used by the MHS and many commercial plans ask beneficiaries to rate various aspects of their health plans. MHS beneficiaries in the United States who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. The civilian benchmark is based on health care system performance metrics from the National Consumer Assessment of Health Plans Survey (CAHPS).

- Satisfaction with the overall TRICARE plan continues to improve each year. Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals and customer complaints.
- Satisfaction with health care quality, one's personal physician, and specialty care under TRICARE, while improving, lags the civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



Source: MPR data, November 2003

Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian health maintenance organization (HMO) and Point of Service (POS) plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

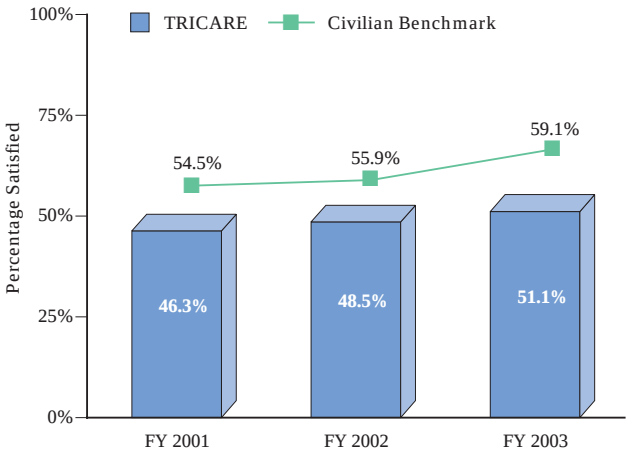
SATISFACTION WITH TRICARE BASED ON ENROLLMENT STATUS

DoD health care beneficiaries can participate in TRICARE in several ways: by enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterpart.

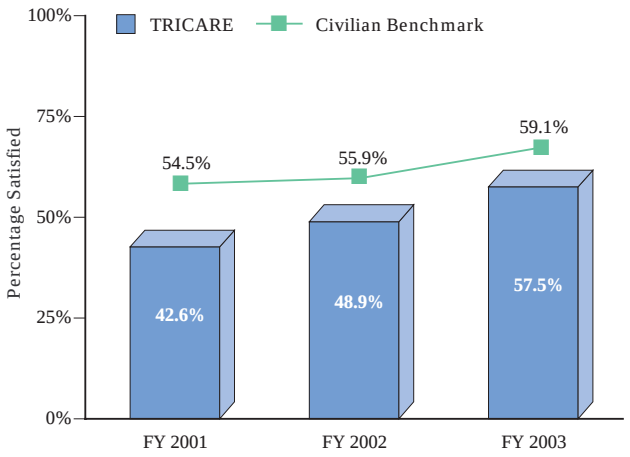
- Overall satisfaction with each TRICARE option continued to improve over the past three years.
- MHS beneficiaries enrolled with military PCMs and those not enrolled at all generally reported lower levels of satisfaction compared to their civilian plan counterparts. However, in 2003 MHS beneficiaries enrolled with civilian network providers reported the same level of satisfaction as the overall civilian level (i.e., not statistically different).

TRENDS IN SATISFACTION WITH TRICARE BASED ON ENROLLMENT STATUS

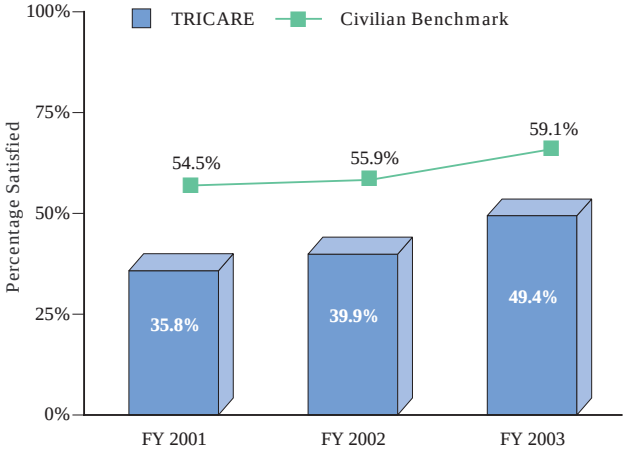
PRIME—MILITARY PCM



PRIME—CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Source: MPR, November, 2003

Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

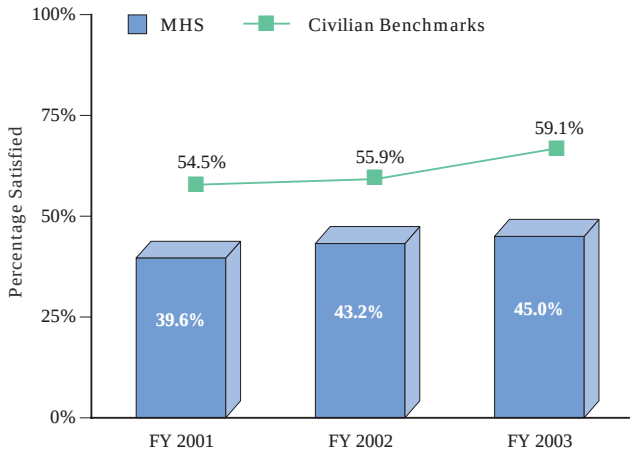
SATISFACTION BY BENEFICIARY CATEGORY

Satisfaction levels of different beneficiary categories are examined to identify any diverging trends between groups.

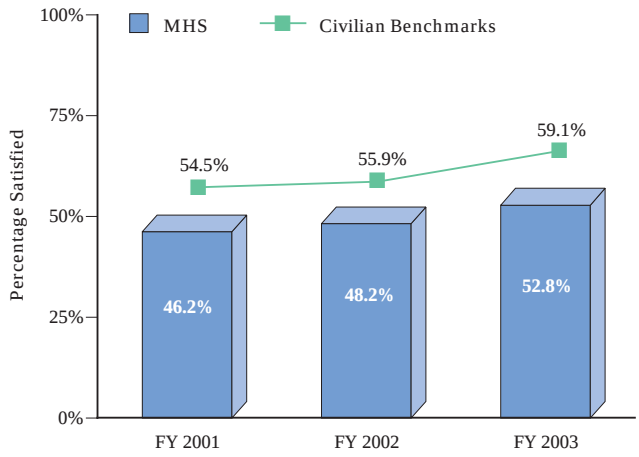
- Satisfaction with TRICARE improved for all beneficiary categories between 2001 and 2003, although the rates continued to lag civilian counterparts for the past three years.
- Satisfaction by retired DoD beneficiaries was comparable to the general population using commercial plans in FY 2003 (no statistical difference).

TRENDS IN SATISFACTION WITH HEALTH PLAN BY BENEFICIARY CATEGORY

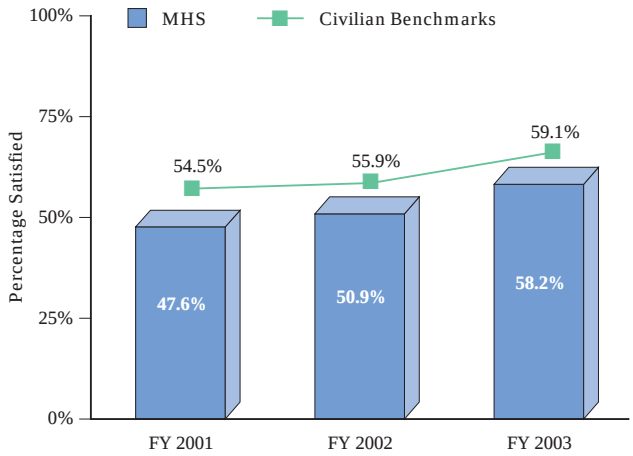
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED



Source: MPR data, November 2003

Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

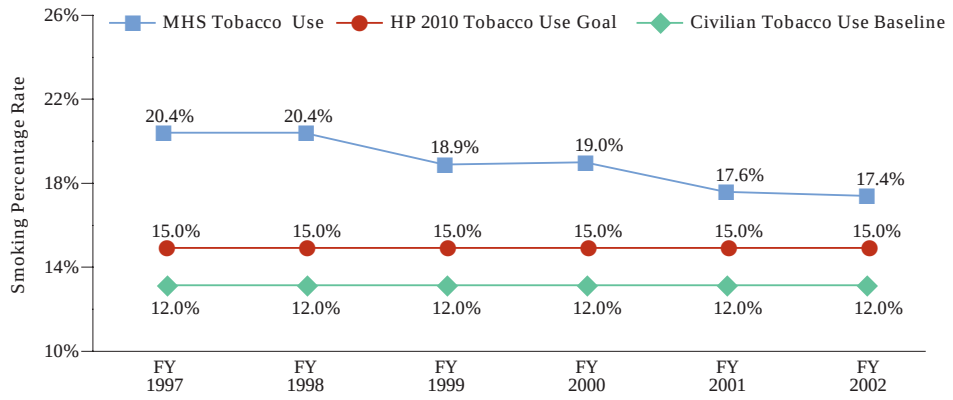
BUILDING HEALTHY COMMUNITIES—HEALTHY PEOPLE 2000 AND 2010 BENCHMARKS

Healthy People (HP)* goals represent the prevention agenda for the nation over the past two decades (http://www.healthypeople.gov/About/). Beginning with goals established for HP 2000 and maturing most recently in HP 2010, this agenda is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. These strategic goals go beyond restorative care and speak to the challenges of institutionalizing population health within the MHS. There are many indices by which to monitor the MHS relative to HP goals and reported civilian progress. The MHS has improved in several key areas, and strives to improve in others. The following present just a few such comparisons.

Tobacco Use

The MHS has improved over the past five years in approaching the HP goals of a 15 percent rate in tobacco use (HP 2000), which has been reduced to 12 percent (HP 2010) for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month. While better than civilian tobacco use, it still lags the HP 2010 goal.

BUILDING HEALTHY COMMUNITY TRENDS—TOBACCO USE



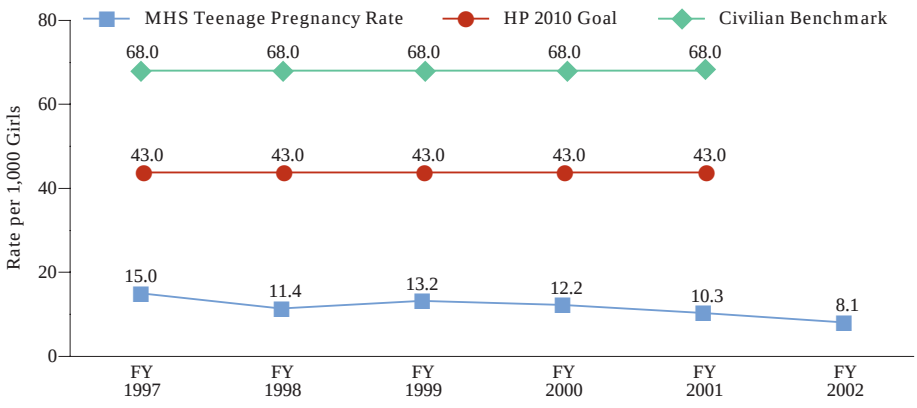
Source: MHS administrative data reported in ASD (HA) Performance Contract metrics

* U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

Family Planning—Teenage Pregnancy

The MHS teenage pregnancy rates continue to be better than the civilian benchmark as well as the HP goals for both HP 2000 (50 per 1,000) and HP 2010 (43 per 1,000), improving further in 2002, the most recently available data.

BUILDING HEALTHY COMMUNITY TRENDS—TEENAGE PREGNANCY



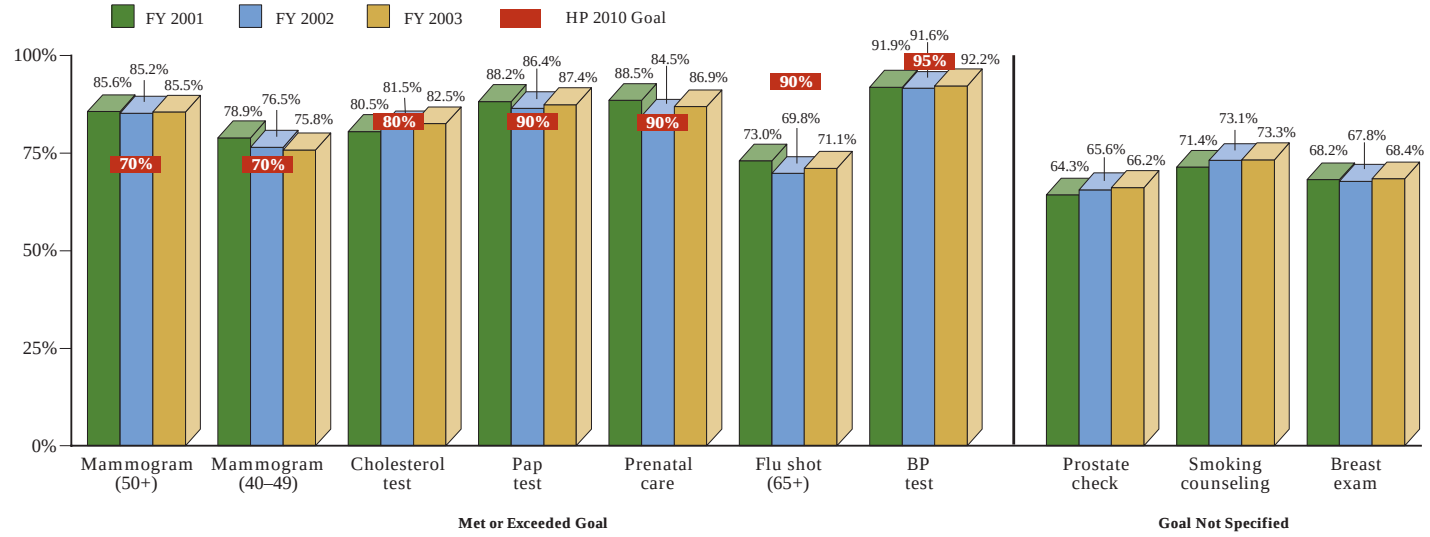
Source: MHS administrative data reported in ASD (HA) Performance Contract metrics

TRENDS IN MEETING PREVENTIVE CARE STANDARDS

The MHS has set as goals selected national health-promotion and disease-prevention objectives specified by the Department of Health and Human Services in HP 2010. These goals and objectives go beyond restorative care and speak to the need to institutionalize population health within the MHS.

- The MHS meets or exceeds targeted HP 2010 goals in providing mammograms (for both ages 40–49 years and 50+ categories) and testing for cholesterol.
- Efforts continue toward achieving Healthy People 2010 standards for pap smears, prenatal exams, blood pressure screening and flu shots (for people age 65 and older). Still other areas continue to be monitored in the absence of specified Healthy People standards, such as breast exams (for those age 40 and over), smoking cessation counseling and prostate exams.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, 2001–2003



Source: Health Care Survey of DoD Beneficiaries and the national CAHPS Benchmarking Database

MHS TARGETED PREVENTIVE CARE OBJECTIVES

Mammogram—Women ages 40–49 who had mammogram in past two years; women age 50 or older who had mammogram in past year.

Cholesterol test—People who had a cholesterol screening in last five years.

Pap test—All women who had a Pap test in last three years.

Prenatal—Women pregnant in last year who received care in first trimester.

Flu shot—People 65 and older who had a flu shot in last 12 months.

Blood Pressure test—People who had a blood pressure check in last two years and know results.

MHS GOALS NOT SPECIFIED BY CURRENT HEALTHY PEOPLE 2010 TARGETS

Prostate check—Men age 50 or older who had a prostrate exam in last 12 months.

Breast exam—Women age 40 or older who had a breast exam in last 12 months.

Smoking cessation counseling—People advised to quit smoking in last 12 months.

SPECIAL STUDY: RESERVE FAMILY MEMBER SATISFACTION

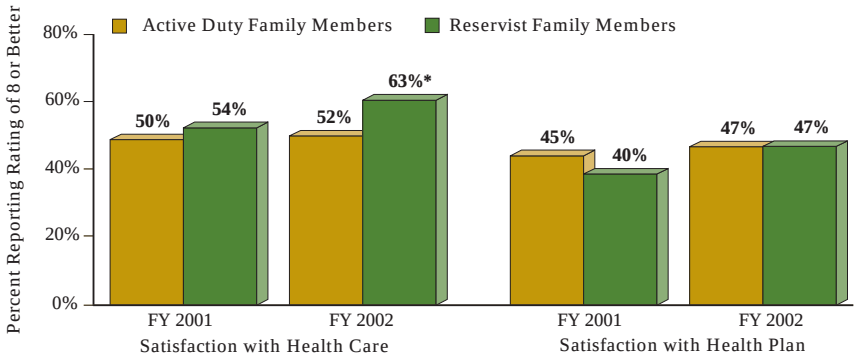
The annual adult Health Care Survey of DoD Beneficiaries (HCSDB) is designed to measure a number of health care-related factors from a sample of all eligible MHS beneficiaries. For comparison (benchmarking) purposes, the HCSDB includes the core CAHPS survey questions used by many of the nation's health plans.

A special study re-examined survey data previously collected to identify satisfaction levels among MHS beneficiaries to try to discern the level of satisfaction of mobilized Reservist family members relative to the general active duty family member population. Data were analyzed based on beneficiary respondents in the 2001 and 2002 routine surveys who indicated they were Prime users during the previous 12 months.

- While not shown here, a higher proportion of reservists responded that they were satisfied with their health care than their active duty counterparts.
- There were no statistically significant differences in the satisfaction ratings of Reservist and ADFMs in any of eight areas surveyed in 2001 (satisfaction with: health plan, doctor, specialty care, getting needed care, getting care quickly, customer service, and claims handling).
- In 2002, a higher proportion of Reservist family members reported satisfaction in the area of health care overall compared to ADFMs. There were no differences in the other seven areas.

COMPARISON OF SATISFACTION: PRIME FAMILY MEMBERS OF MOBILIZED RESERVISTS AND PRIME ACTIVE DUTY FAMILY MEMBERS

Comparison of Satisfaction Between Family Members of Mobilized Reservists and Active Duty Family Members



Source: Health Care Survey of DoD Beneficiaries and the national CAHPS Benchmarking Database

* Indicates a statistically significant difference ($p < 0.05$) between Active Duty Family Members and Family Members of Mobilized Guard / Reservists.

Most health care readiness metrics focus on those unique aspects germane to each of the Services, and are presented by the Surgeons General as appropriate to their combat leadership. Other readiness metrics are classified and presented elsewhere, as appropriate. Finally, we are in the process of developing and standardizing several common baseline measures that will need to mature over the next year. One such measure that has helped define one critical aspect of medical readiness comes from our dental community.

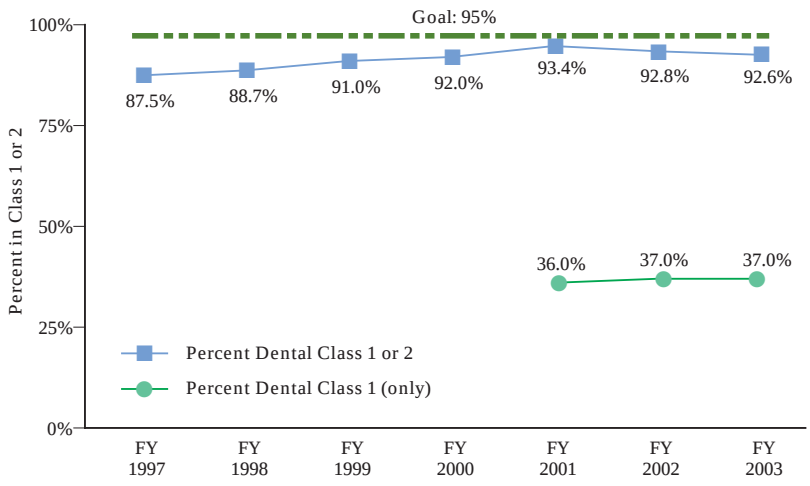
DENTAL READINESS

In 1996, the Service Dental Corps Chiefs established a Dental Readiness goal of maintaining at least 95 percent of all active duty personnel in Dental Class 1 or 2. While a measure of detal readiness, this goal also effectively measures active duty access to necessary dental services. Patients in Dental Classes 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or who require nonurgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). The results for FY97–FY03 are presented below.

- While the overall MHS rate of dental readiness for Classes 1 and 2 has generally increased since the metric was established, the target rate of 95 percent has not yet been achieved.
- In addition, Dental Class 1 percentages demonstrate a less than optimal state of dental health (Dental Class 1) for active duty personnel.

DENTAL READINESS

Active Duty Dental Readiness: Percent Dental Class 1 or 2



Data source: The Services' Dental Corps–DoD Dental Readiness Classifications

Dental Class 1 (Dental Health or Wellness): Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are world-wide deployable.

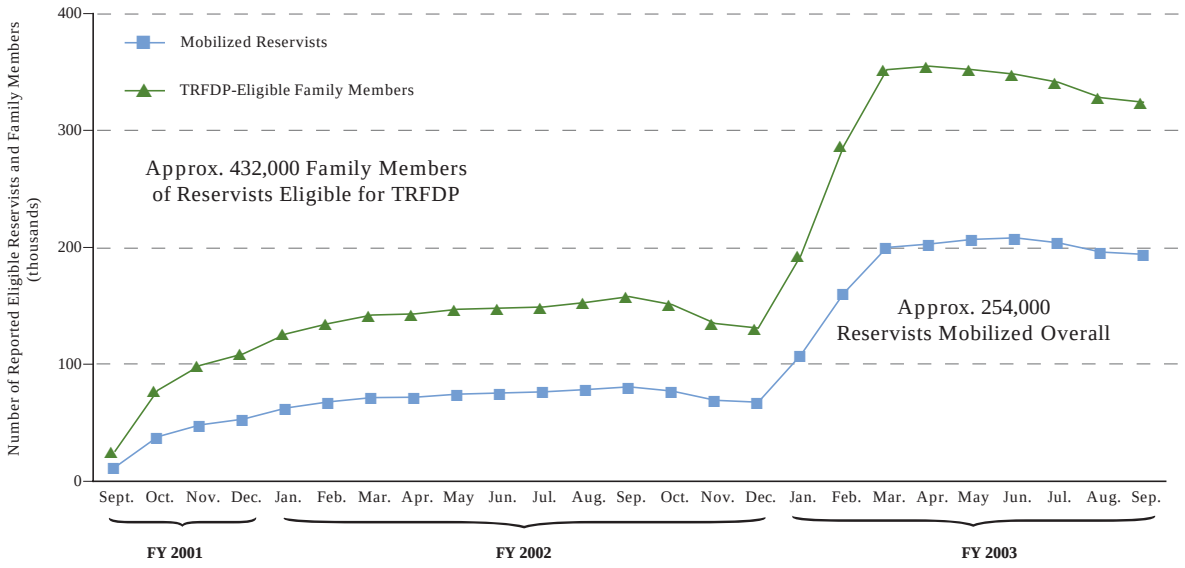
Dental Class 2: Patients with a current dental examination, who require nonurgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are world-wide deployable.

SPECIAL STUDY: TRICARE SUPPORT FOR FAMILIES OF MOBILIZED RESERVISTS

TRICARE supported the Global War on Terrorism shortly after 9-11-01 through a rapidly deployed health benefits demonstration project known as the TRICARE Reserve Family Demonstration Project (TRFDP). This Demonstration supported the family members of mobilized reservists by waiving certain administrative and financial requirements that might be expected to present obstacles to a group of beneficiaries who would not be familiar with TRICARE, yet who were likely to be involved with other health insurance for their own civilian providers.

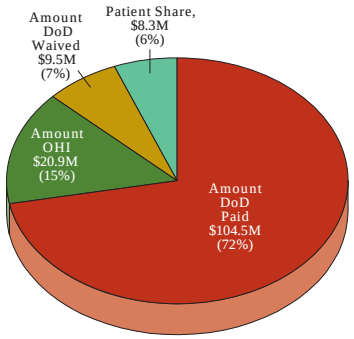
- Between September 2001 and August 2003, over 254,000 National Guard and Reservists were mobilized for Operations Noble Eagle, Enduring Freedom and Iraqi Freedom. As a result of their mobilization for active duty, their 432,000 family members were eligible for the TRFDP benefit during this period of time.
- During this time, a total of $143 million was spent for purchased care services for these family members, paid by the DoD ($114 million, or 79 percent), patients ($8 million, or 6 percent) and patients' other health insurance (OHI, $21 million, or 15 percent). The DoD waived almost $10 million in patient cost shares specifically authorized by the Demonstration.

MONTHLY MOBILIZED GUARD AND RESERVISTS AND TRFDP – ELIGIBLE FAMILY MEMBERS (SEPT. 2001–SEPT. 2003)



Source: DEERS data

COMPOSITION OF ALL PAYMENTS FOR TRFDP PURCHASED CARE SERVICES (SEPT. 2001–SEPT. 2003)



Source: MHS administrative data

Quality metrics focus on four areas: (1) reported access to MHS care overall, (2) satisfaction with various aspects of the MHS system, (3) successful access by active duty for necessary dental care, and (4) minimizing preventable admissions.

ACCESS TO MHS CARE

Using survey data, three categories of access to care were considered:

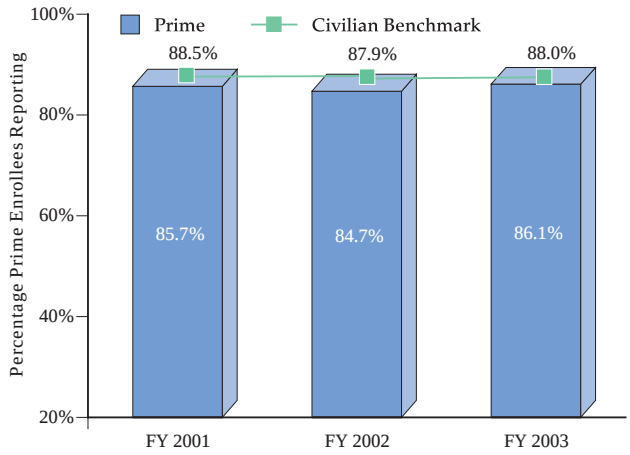
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.

Overall Outpatient Access

Ability to see a doctor reflects successful access to the health care system.

- Access to and use of outpatient services remains high.
- Prime enrollees reporting they had at least one outpatient visit in the past year increased between FY 2002 and FY 2003, comparable to their civilian counterparts enrolled in managed care plans.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR



Source: MPR Data, November 2003

Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

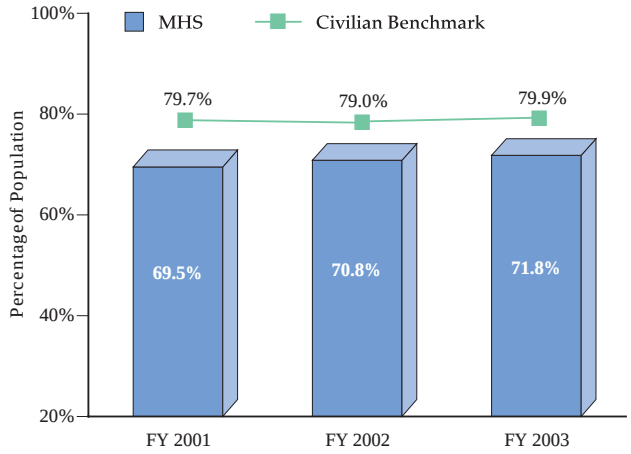
Availability and Ease of Obtaining Care

Availability and efficiency of obtaining care can be characterized by the extent to which beneficiaries report their ability to (1) receive care when needed, (2) obtain appointments in a timely fashion, and (3) face minimal, unnecessary waits in the doctor's office.

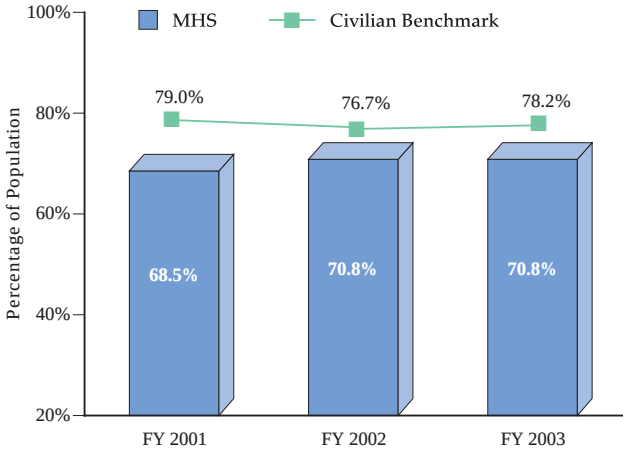
- MHS beneficiary ratings improved in all three categories over the three-year period between FY 2001 and FY 2003 (significant between FY 2001 and FY 2003).
- In the past two years, a higher proportion of MHS beneficiaries reported their waiting time to see a doctor was less than 15 minutes compared to the civilian benchmark (statistically significant for FYs 2002 and 2003).

TRENDS IN AVAILABILITY AND EASE OF OBTAINING CARE FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)

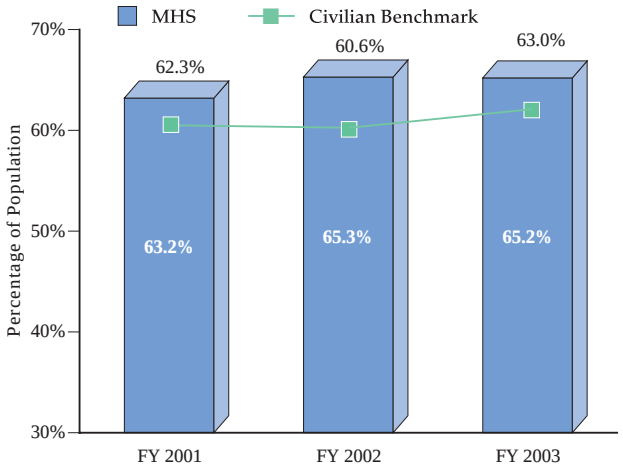
GOT NECESSARY CARE



WAITED FOR ROUTINE VISIT



WAITED LESS THAN 15 MINUTES TO SEE DOCTOR



Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

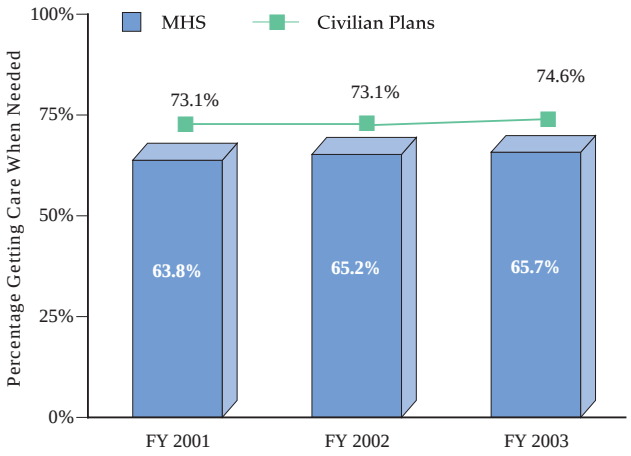
Ability to Obtain Care by Beneficiary Category

In focusing on beneficiary ability to obtain necessary care, differences between beneficiary categories are considered as well to identify significant disparities of concern.

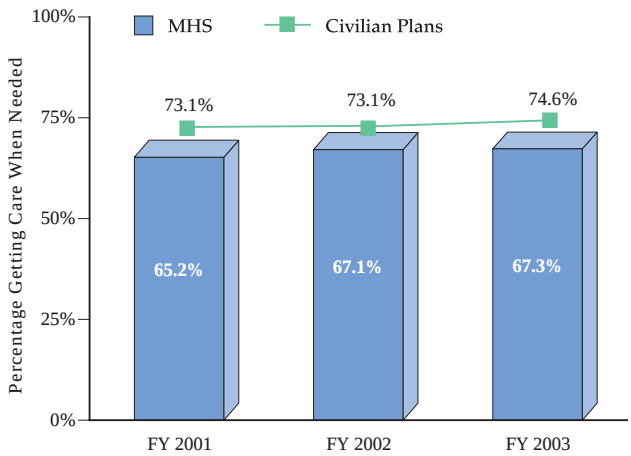
- Retired beneficiaries are increasingly reporting they are able to receive care when they need it (significant between FY 2001 and FY 2003), and their level of access is comparable to civilian access (significant for FY 2002 and FY 2003).
- Active duty beneficiaries and their family members continue to lag their civilian counterparts in reporting access to care when needed.

TRENDS IN AVAILABILITY OF OBTAINING CARE BY BENEFICIARY CATEGORY (ALL SOURCES OF CARE)

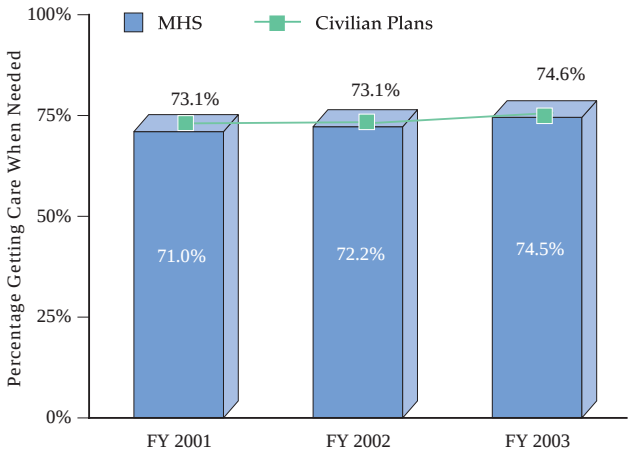
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



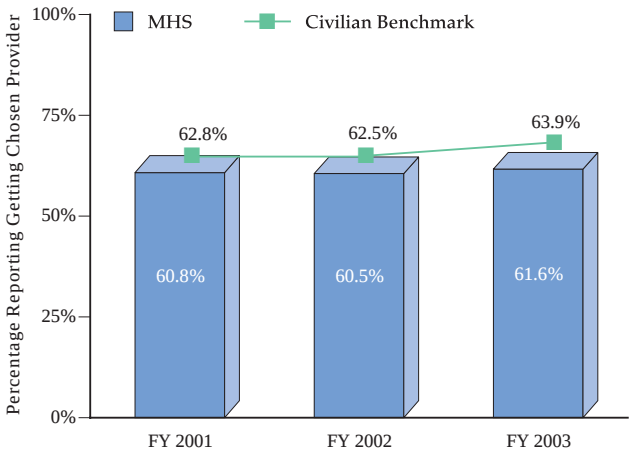
Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

Opportunity to Get a Health Provider of Choice

Being able to choose a doctor or nurse one is happy with is a major determinant of an individual's satisfaction with a health plan.

- The majority (62 percent in FY 2003) of MHS beneficiaries are able to get a provider they are happy with.
- The DoD trend and level of satisfaction in obtaining a provider of choice continues to lag comparable commercial health plans.

TRENDS IN GETTING A DOCTOR OR NURSE OF ONE'S CHOICE



Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

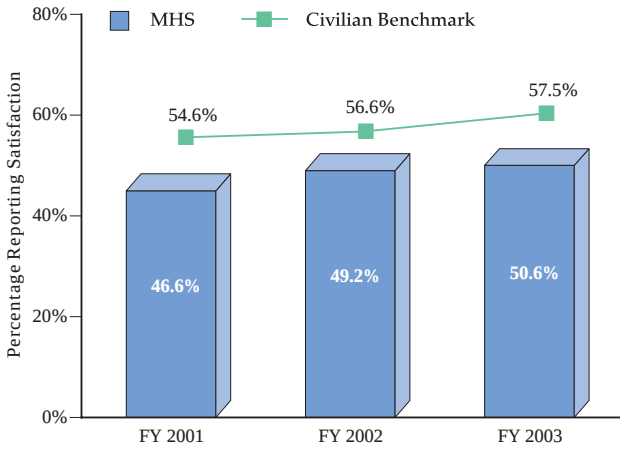
Satisfaction with Customer Service

Access to and understanding of written materials about one's health plan is an important determinant of overall satisfaction with the plan.

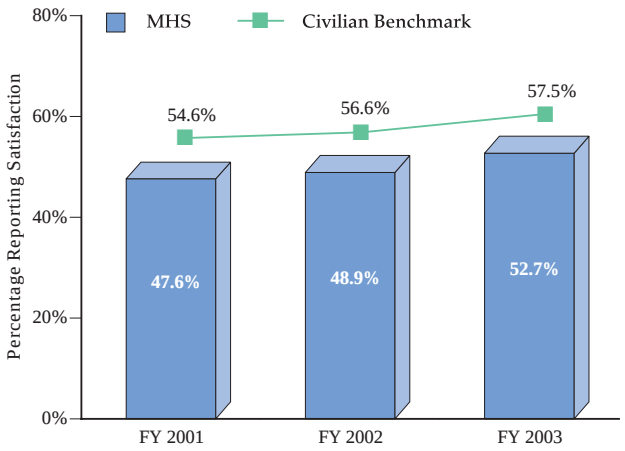
- MHS customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork improved between FY 2001 and FY 2003. Enrollees and non-enrollees alike reported higher levels during this time.
- Those enrolled in Prime (both with military providers as well as with civilian providers) reported fewer problems with customer service compared to those who were not enrolled.
- Ratings for TRICARE customer service were not as high as those reported by enrollees in commercial plans.

TRENDS IN RESPONSIVE CUSTOMER SERVICE:
COMPOSITE MEASURE OF FINDING, UNDERSTANDING WRITTEN MATERIAL; GETTING CUSTOMER ASSISTANCE & PAPERWORK

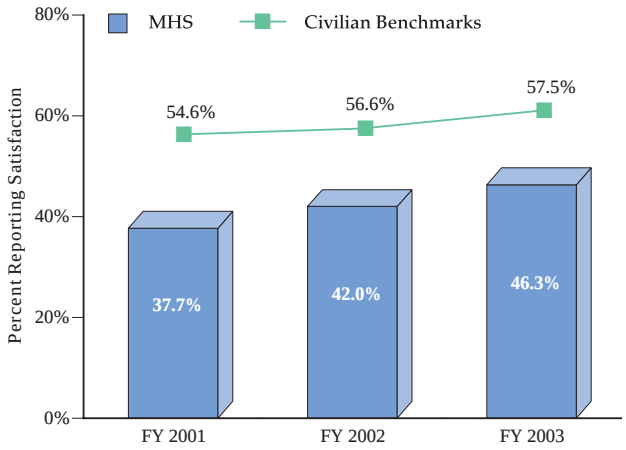
PRIME—MILITARY PCM



PRIME—CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Source: MPR Data, November 2003

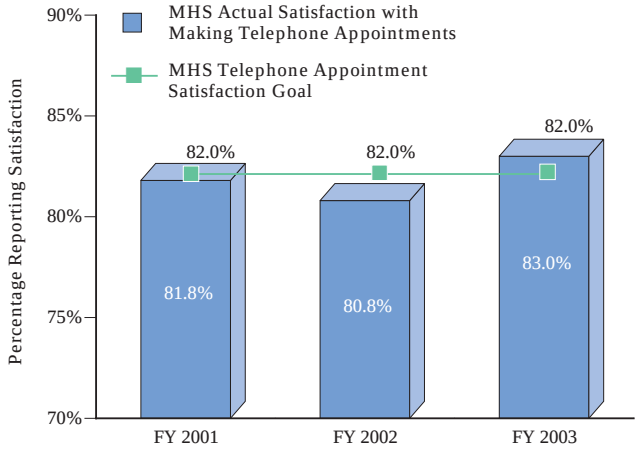
Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and POS plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

APPOINTMENT ACCESS IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with telephonic access to the direct care system in addition to the satisfaction metrics presented above (External Customers: satisfaction with the health plan and care overall, as well as the primary care and specialty care physicians). This metric is designed to put MHS patients at the center of everything in the direct care system.

The MHS goal of 82 percent of patients reporting satisfaction with making appointments by telephone was met in FY 2003.

SATISFACTION WITH MAKING APPOINTMENTS BY TELEPHONE IN THE DIRECT CARE SYSTEM



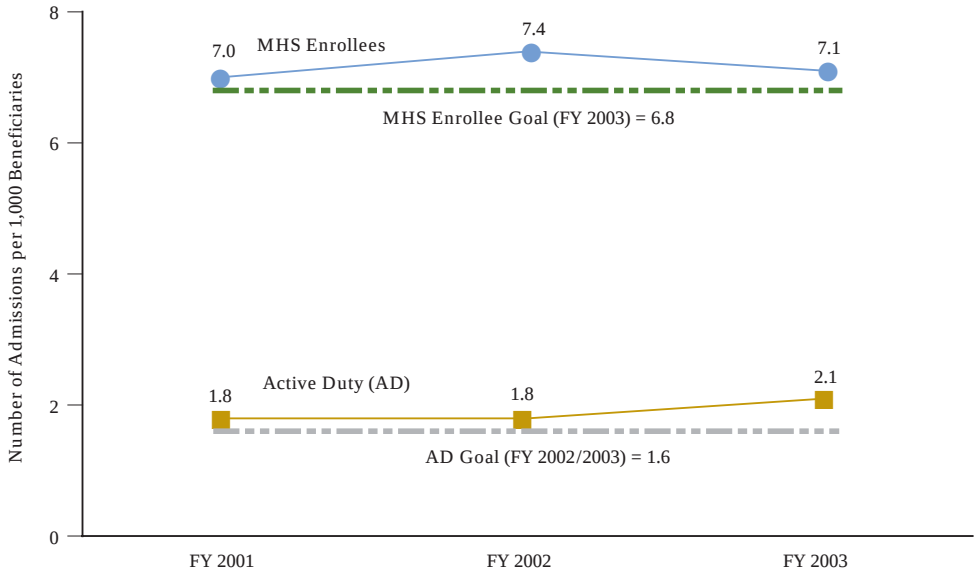
Source: DHP Performance Contract (Q-2 Report) - Satisfaction with Access, October 28, 2003

PREVENTABLE ADMISSIONS

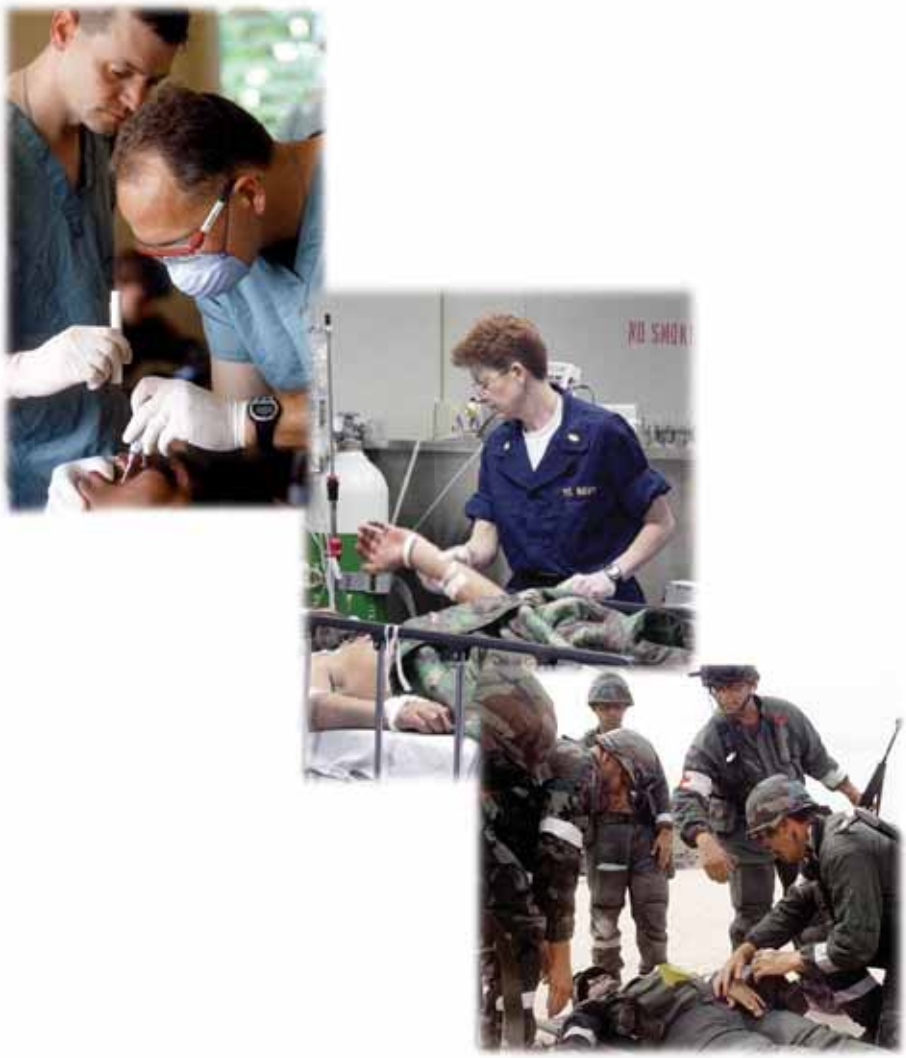
Preventable admissions by Prime enrollees (using both direct and purchased care) are determined as specific diagnoses in nine clinical categories: chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, angina, cellulitis, diabetes, gastroenteritis, and kidney / urinary infections.

- The overall rate of preventable admissions (per 1,000 beneficiaries) for all MHS enrollees remained the same between FY 2001 and FY 2003.
- The preventable admission rate for active duty personnel increased from FY 2001 to FY 2003 (from 1.8 to 2.1 per 1,000 members).
- The preventable admission rates for both active duty and all MHS enrollees were higher than the desired goals (1.6 for active duty and 6.8 for enrollees).

TRENDS IN MHS PREVENTABLE ADMISSIONS PER 1,000 BENEFICIARIES (BASED ON RELATIVE WEIGHTED PRODUCTS)



Source: Performance Contract between Defense Resources Board and Assistant Secretary of Defense (Health Affairs), FY 2001–FY 2003. To assist in comparability between hospitals, admission rates are adjusted by DRG weights to account for differences in relative resource consumption of a patient's hospitalization.

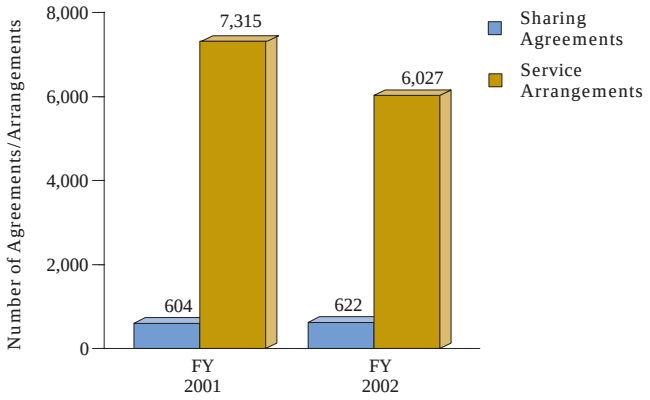


AGENCY INTEROPERABILITY: NUMBER OF DoD/VA SHARING AGREEMENTS

The "Department of Veterans Affairs (DVA) and the DoD Health Resources Sharing and Emergency Operations Act" (38 USC Section 8111(f)) requires the Secretary of Veterans Affairs and the Secretary of Defense to report to Congress the ongoing status of sharing of health care resources between the two Departments. The VA and DoD established joint guidelines in 1983 promoting the sharing of relevant clinical or administrative services.

- While the total number of sharing Agreements (i.e. Memos of Understanding, contracts, etc.) between DoD and VA facilities increased 3 percent from FY 2001 to FY 2002, the number of arrangements (i.e., shared services or areas of collaboration, such as clinical services, nursing education; telemedicine; informatics, etc.) decreased by almost 18 percent. The drop in the number of services being shared is due largely to the termination of sharing agreements with the Military Medical Support Office and transfer of workload to TRICARE.
- Areas of recent collaboration include (as reported in the FY 2002 Report):
  - Information Management and Technology
  - Clinical Practice Guidelines and Patient Safety reporting systems
  - Joint management of pharmacy benefits and joint partnerships for contracting for pharmaceuticals
  - Medical / Surgical Supplies, including migration to a single Federal pricing instrument, the Federal Supply Schedule, for medical / surgical products
  - Benefits Coordination, including evaluation of potential sharing with respect to Geriatric Care, skilled nursing and home health programs
  - Joint Facility Utilization and Resource Sharing.

NUMBER OF DoD AND VA JOINT SHARING AGREEMENTS AND SERVICE ARRANGEMENTS



Source: FY 2002 DoD / VA Sharing Report to Congress

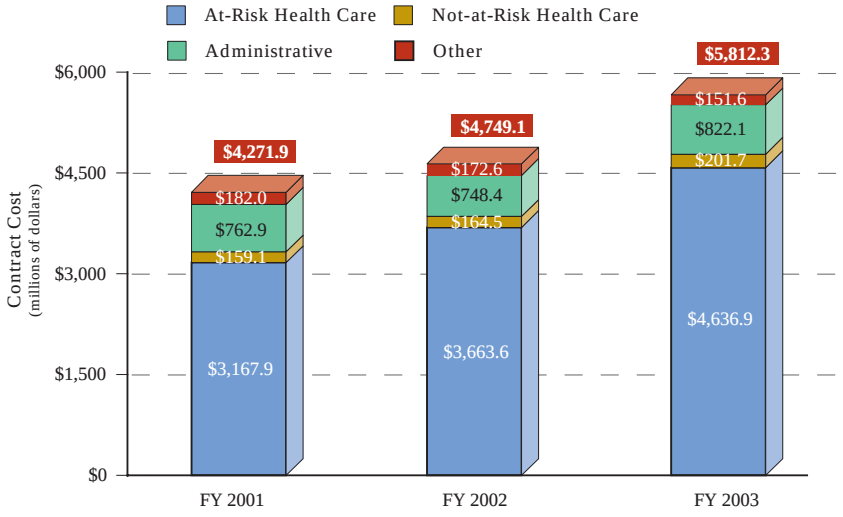
SYSTEM PRODUCTIVITY: SUPPORT CONTRACT MANAGEMENT

FY 2003 Health Services and Support Contract Costs

The cost of purchased care to the DoD is determined by the value of the fixed-price health services and support contracts (including change orders and bid-price adjustments), plus costs for which the contractor is not at risk (e.g., care referred to the network on behalf of MTF-enrolled beneficiaries in Regions 1, 2, and 5, and payments by the contractor for active duty service members enrolled in TRICARE Prime Remote). Actual contract costs were determined for each option period (which vary from region to region) and allocated to fiscal year based on how the option periods and fiscal years overlapped. Health care and administrative expenses for TFL / TSRx claims are excluded from the chart below as they are funded by the Medicare-Eligible Retiree Health Care Fund.

- The total estimated expense incurred by the DoD for the health services and support contracts increased from $4,272 million in FY 2001 to $5,812 million in FY 2003. This represents an increase of 36 percent. The total includes miscellaneous contract pass-through costs, such as capital construction and direct medical education (labeled as "Other" below).
- Administrative expenses have declined from 19.4 percent of total contract revenue (the sum of at-risk health care and administrative expenses) in FY 2001 to 15.1 percent in FY 2003.

HEALTH SERVICES AND SUPPORT CONTRACT COSTS



Source: TMA Contract Cost Data

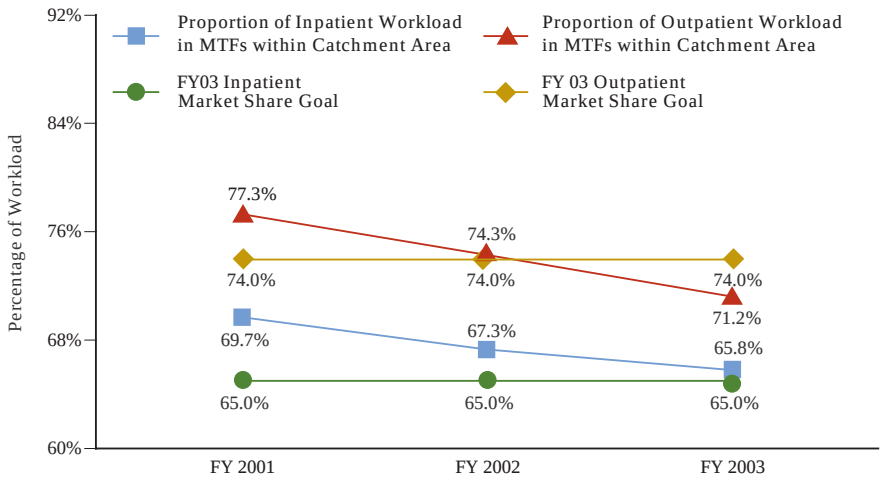
SYSTEM PRODUCTIVITY: MTF AMBULATORY AND INPATIENT MARKET SHARE TRENDS

The percentage of both inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past three years.

From FY 2001 to FY 2003 (3rd Quarter), MTF workload market shares have declined by about 4 percent (inpatient) and 6 percent (outpatient).

No adjustments have been made to account for the effects of deploying military providers and support staff.

PERCENTAGE OF WORKLOAD PERFORMED BY MTFs IN CATCHMENT AREAS



Source: MHS administrative data reported in Performance Contract metrics

Note: Market share measures exclude TFL workload from purchased care. Inpatient workload is based on RWPs, and outpatient workload is based on visits. Inpatient workload is based on 40-mile catchment population; outpatient workload is based on catchment areas for stand-alone clinics and 20-mile catchment area surrounding the "Parent" MTF with inpatient services.

SYSTEM PRODUCTIVITY: CLAIMS PROCESSING

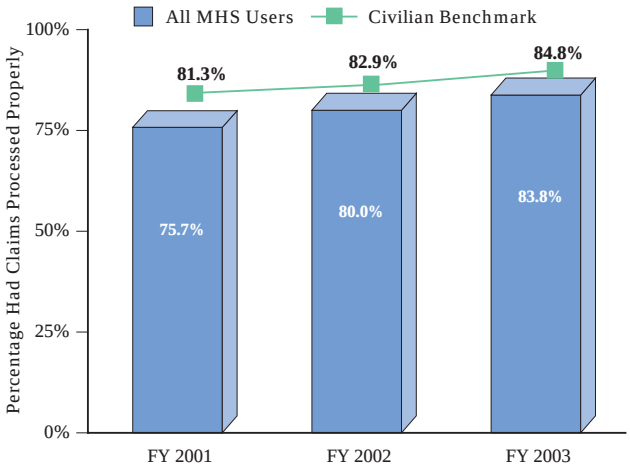
Beneficiary Perceptions of Claims Filing Process

MHS beneficiaries increasingly report their claims are processed properly (almost 84 percent) and in a reasonable period of time (80 percent). This increase is statistically significant between FY 2001 and FY 2003 for both measures.

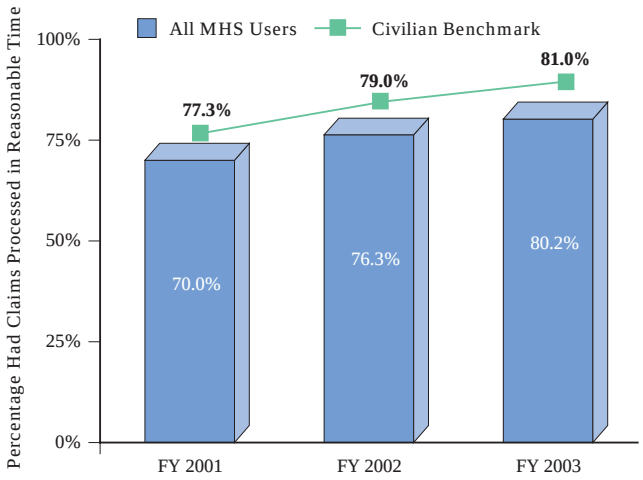
Beneficiary satisfaction with TRICARE claims processing is improving over time; also, by FY 2003 MHS beneficiaries reported the same level of satisfaction as civilian patients with their claims processing time.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE)

CLAIMS PROCESSED PROPERLY (IN GENERAL)



CLAIMS PROCESSED IN REASONABLE TIME



Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied." All DoD results are compared to results from commercial civilian HMO and Point of Service plans. Data for DoD were derived from the 2001–2003 DoD Surveys of Health Care Beneficiaries. "All MHS Users" applies to survey respondents in the United States (regions 1–12), excluding overseas. The civilian benchmark is based on more than 300,000 survey responses from privately insured HMO and POS enrollees contained in the National CAHPS Benchmarking Database. Results were adjusted for differences in age and health status.

Source: MHS administrative data

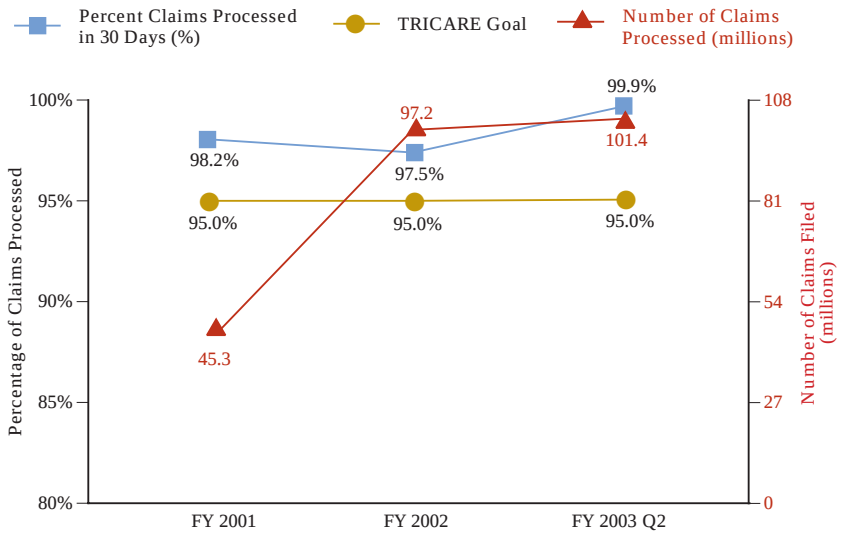
SYSTEM PRODUCTIVITY: CLAIMS PROCESSING *(CONT'D)*

Administratively-Tracked Claims Filing Process

Even with the trebling of total claims processed between FY 2000 and FY 2003 (from almost 34 million in FY 2001 to over 100 million in FY 2003), claims processing turnaround time has improved over the past three years.

- The processing of retained claims within 30 days exceeded the TRICARE goal of 95 percent over the past three years.
- Although not shown on the graph, almost 100 percent of claims are now being processed within 60 days.
- The number of claims filed increased between FY 2001 and FY 2002 with the introduction of the TFL (October 2001) and TSRx (April 2001) benefits.

PERCENTAGE OF TRICARE RETAINED CLAIMS PROCESSED WITHIN 30 DAYS



Source: MHS administrative data

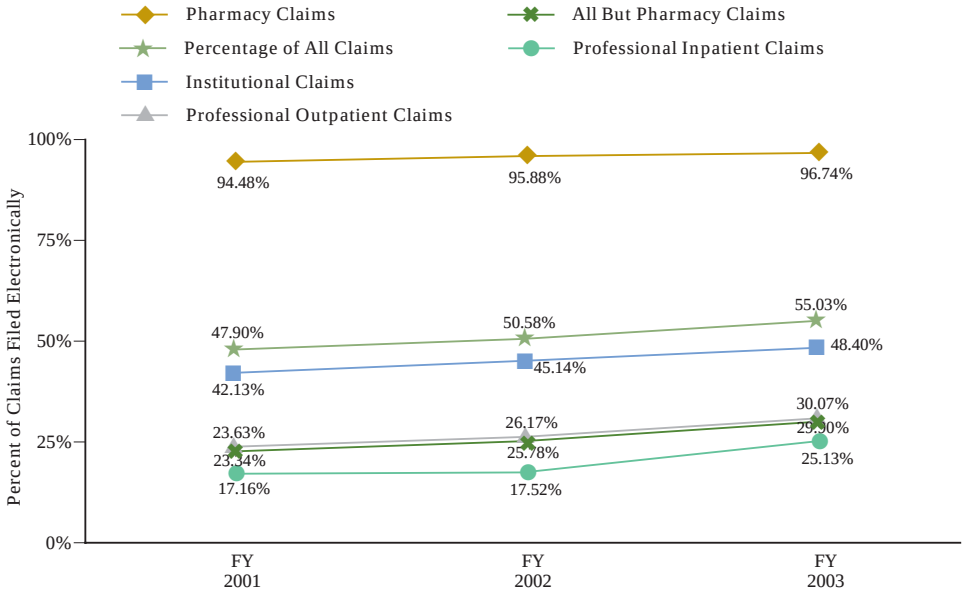
SYSTEM PRODUCTIVITY: CLAIMS PROCESSING *(CONT'D)*

Trends in Electronic Claims Filing

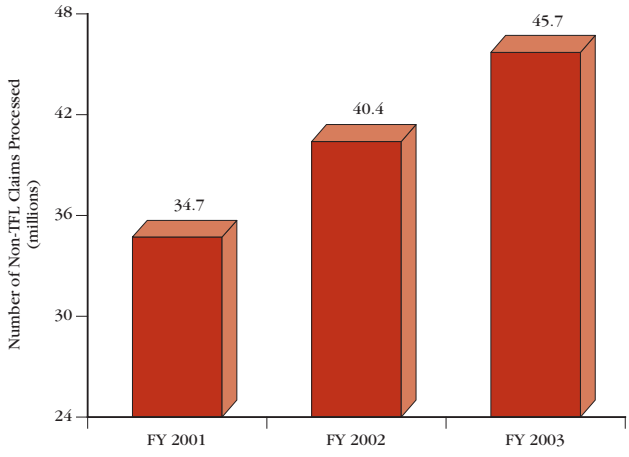
Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in more prompt payment to the provider.

- The percentage of the over 45 million non-TFL claims processed electronically increased to over 55 percent by the end of FY 2003, up almost 5 percentage points from 50.6 percent in FY 2002. TFL claims are excluded because TRICARE is second payer to Medicare, and, as such, the TFL claims are predominantly electronic, irrespective of MHS involvement.
- Pharmacy claims continue to reflect the bulk of electronic claims. When these claims are excluded from consideration, the percentage of remaining claims (institutional, and professional inpatient and outpatient services) has increased by about 3 percent, reaching almost 30 percent in FY 2003.

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF CLAIMS FILED ELECTRONICALLY



NUMBER OF NON-TFL CLAIMS PROCESSED



Source: MHS administrative data, November 2003

Note: Above excludes foreign and TFL claims; claim counts are for "net" records based on suffix "A" only.

INPATIENT UTILIZATION RATES AND COSTS

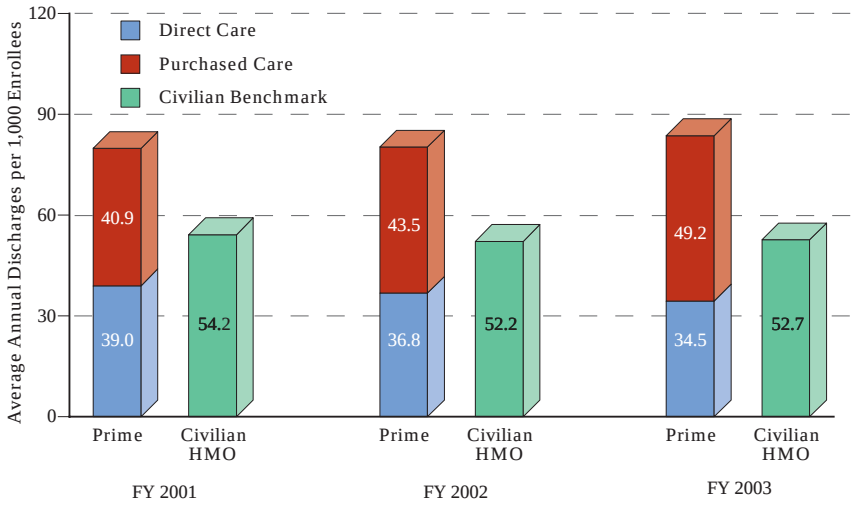
TRICARE Inpatient Utilization Rates Compared to Civilian Benchmarks

TRICARE Prime Enrollees

This section compares the utilization of TRICARE Prime enrollees with that of civilian Health Maintenance Organization (HMO) enrollees.

- The TRICARE Prime enrollee inpatient utilization rate (direct and purchased care combined) was almost 60 percent higher than the civilian HMO enrollee utilization rate in FY 2003 (83.7 discharges per thousand Prime enrollees compared with 52.7 per thousand civilian HMO enrollees).
  - The Prime enrollee utilization rate (discharges per 1,000 enrollees) increased from 79.9 in FY 2001 to 83.7 in FY 2003, while the rate of their civilian counterparts decreased from 54.2 to 52.7 during the same period.
- While direct care utilization decreased by 12 percent from FY 2001 to FY 2003, the decrease was offset by a 20 percent increase in purchased care utilization.

INPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database

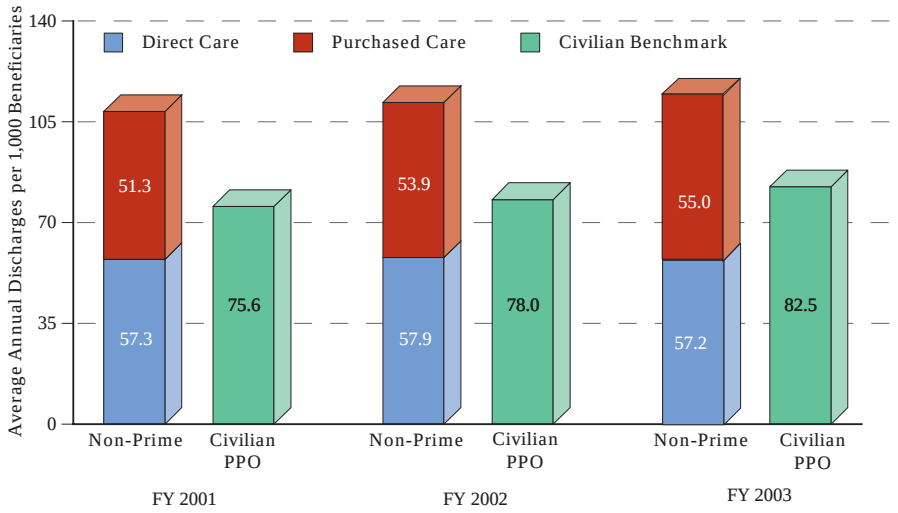
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Beneficiaries Not Enrolled In TRICARE Prime

This section compares the utilization of beneficiaries not enrolled in TRICARE Prime with that of civilian participants in Preferred Provider Organization (PPO) plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, nonenrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the presentation below. In particular, all results exclude the effect of TFL.

INPATIENT UTILIZATION: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK

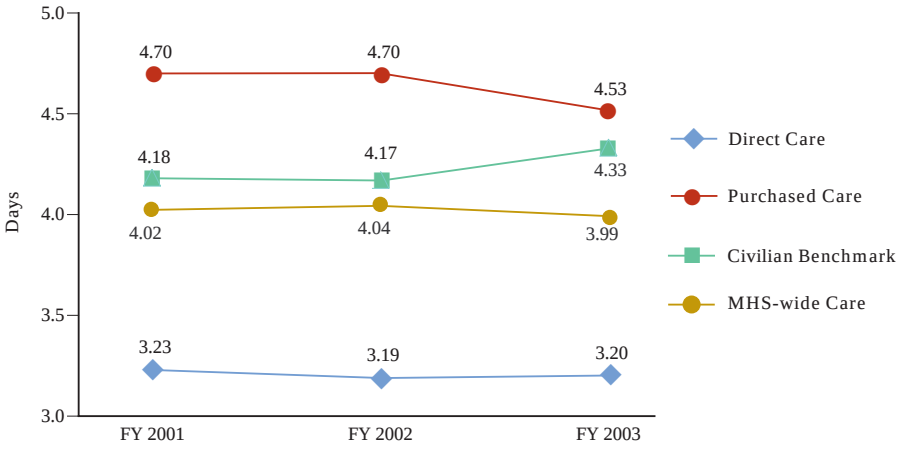


Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

- Although TRICARE non-Prime inpatient utilization increased over 3 percent from FY 2001 to FY 2003, (from about 109 discharges per 1,000 beneficiaries to 112), the civilian inpatient utilization increased by 9 percent. Consequently, the disparity between total TRICARE non-prime inpatient utilization and the levels observed in civilian PPOs narrowed in FY 2003.
- The TRICARE non-Prime direct care inpatient utilization rate remained essentially constant from FY 2001 to FY 2003.
- The TRICARE non-Prime purchased care inpatient utilization rate increased by 7 percent from 51.3 discharges per 1,000 beneficiaries in FY 2001 to 55.0 discharges per 1,000 beneficiaries in FY 2003.

INPATIENT UTILIZATION: TRENDS IN TRICARE AVERAGE LENGTH OF STAY



Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database

Note: Beneficiaries age 65 and over were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (direct and purchased care combined). FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

Average Lengths of Hospital Stays

- Average lengths of stay in DoD facilities (direct care) remained essentially constant during the period from FY 2001 to FY 2003.
- Average lengths of stay in TRICARE network facilities (purchased care) declined somewhat during the period from FY 2001 to FY 2003 but remained above those in DoD facilities. Hospital stays in network facilities are longer on average than in DoD facilities because network facilities perform more complex procedures (as determined by a measure of inpatient resource intensity).
- Average length of stay in benchmark civilian facilities took a turn upward in FY 2003, and remains above that of MHS-wide care.

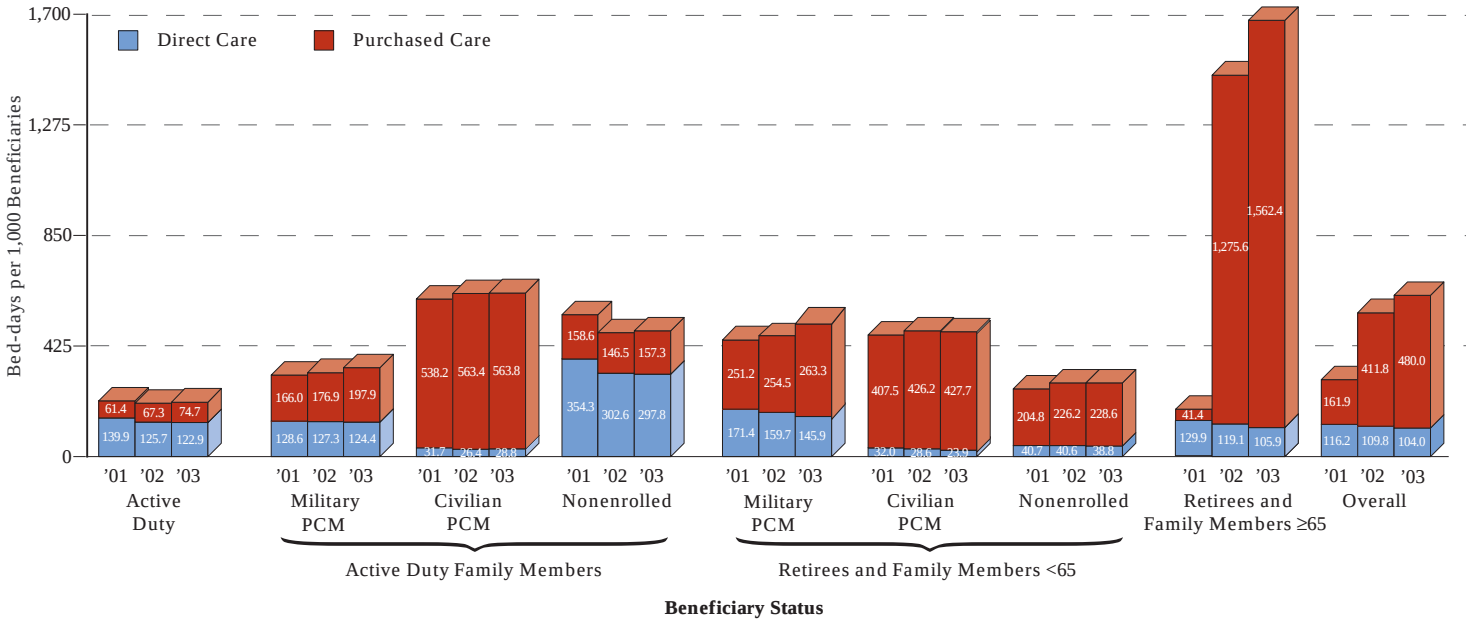
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, bed-days per capita should more accurately reflect differences across beneficiary groups than discharges per capita.

- With the exception of retirees and family members age 65 and over, total inpatient utilization rates (bed-days per 1,000 beneficiaries) remained about the same for most beneficiary groups.
- The reported utilization of DoD-sponsored inpatient care rose sharply for Medicare-eligible beneficiaries with the introduction of the TFL benefit in FY 2002, and increased further in FY 2003. However, the apparent increase in utilization by these beneficiaries in FY 2002 is illusory. Roughly the same levels of utilization were probably experienced in FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer to Medicare), about two-thirds of all inpatient workload was performed in the network.
- In FY 2001, half the inpatient workload generated by beneficiaries enrolled with a military PCM (including active duty personnel) was referred to the network. That percentage increased to 52 percent in FY 2002 and to 55 percent in FY 2003.

AVERAGE ANNUAL INPATIENT BED-DAYS PER 1,000 BENEFICIARIES (BY FISCAL YEAR)



Source: MHS administrative data

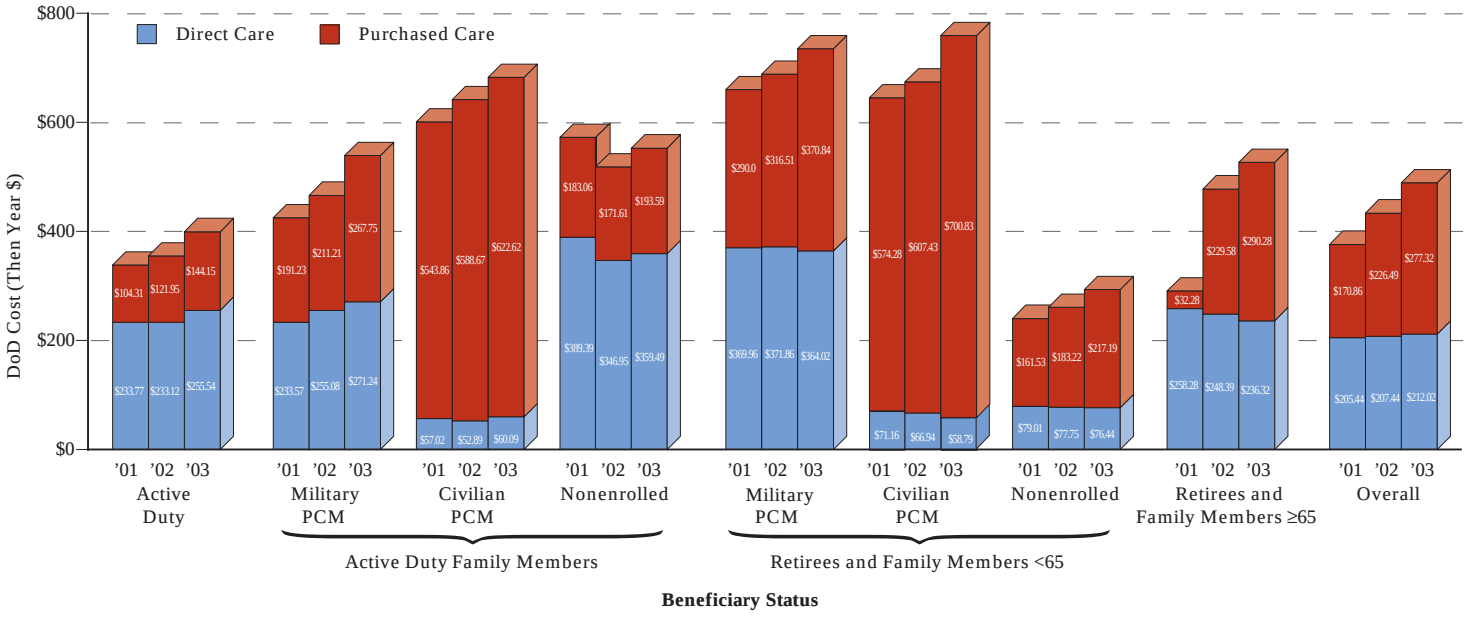
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Cost by Beneficiary Status

Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right bars below) rose substantially due to the TFL benefit extended to Medicare-eligible beneficiaries in FY 2002.

For all beneficiary groups except nonenrolled ADFMs, MHS inpatient cost per beneficiary increased between FY 2001 and FY 2003.

AVERAGE ANNUAL DoD INPATIENT COST PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data

INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Volume

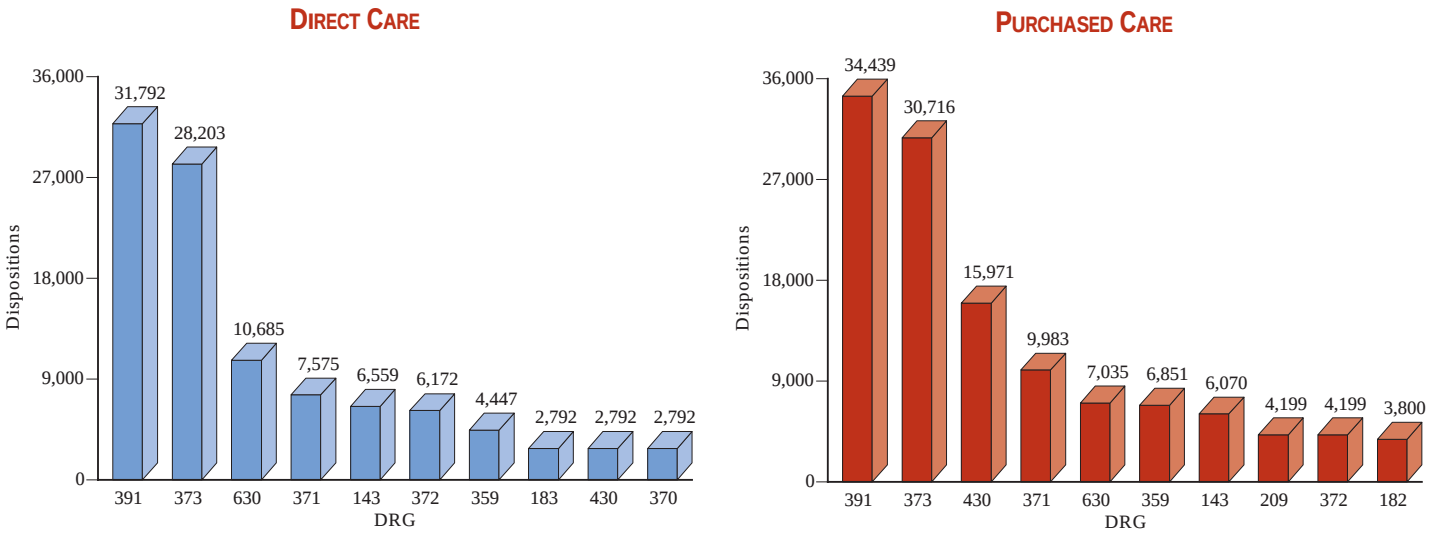
In military hospitals (direct care), the top 10 Diagnosis-Related Groups (DRGs) in terms of dispositions (discharges from the hospital) accounted for 42 percent of all direct care inpatient dispositions.

- Half of these DRGs were associated with childbirth.
- The top two procedures, associated with normal childbirth, together account for more volume than the next eight procedures combined.

In contract network hospitals (purchased care), the top 10 DRGs accounted for 39 percent of all purchased care inpatient dispositions. TFL dispositions are excluded.

- Of the top 10 DRGs, four were related to childbirth.
- Similar to that noted in the direct care (above), the top two procedures in purchased care are associated with normal childbirth, and together account for more volume than the next eight procedures combined.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2003 BY VOLUME



Source: MHS administrative data

DRG	DESCRIPTION
143	Chest pain
182	Esophagitis, gastroenteritis & miscellaneous digestive disorders age >17 w/ cc
183	Esophagitis, gastroenteritis & miscellaneous digestive disorders age >17 w/o cc
209	Major joint & limb reattachment procedures of lower extremity
359	Uterine & adnexa procedure for non-malignancy w/o cc
370	Cesarean section w/cc
371	Cesarean section w/o cc
372	Vaginal delivery w/complicating diagnoses
373	Vaginal delivery w/o complicating diagnoses
391	Normal newborn
430	Psychoses
630	Neonate, birth weight >2499g, without significant operating room procedure, with other problems

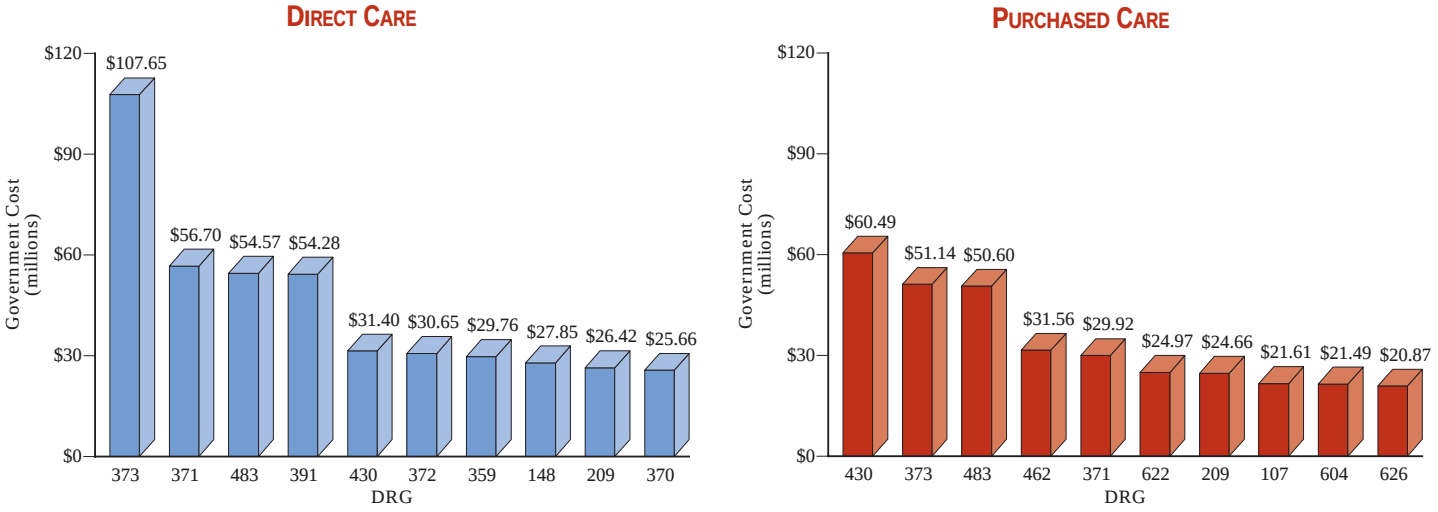
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Cost

The leading diagnoses in terms of cost in FY 2003 were determined from institutional claims only, i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges.

- In military hospitals (direct care) the top 10 DRGs in terms of cost accounted for 26 percent of all direct care inpatient costs.
  - Half of these DRGs were associated with childbirth.
  - Although not one of the top 10 diagnoses in terms of volume, tracheostomies (except for face, mouth, and neck diagnoses) ranked third in terms of total inpatient expenditures at DoD facilities in FY 2003 because of their long average hospital stays (41 days).
- In contract network hospitals (purchased care), the top 10 DRGs accounted for 24 percent of all purchased care inpatient costs. TFL claims are excluded.
  - Psychiatric conditions accounted for the greatest MHS expenditures for a single DRG at network facilities, followed by normal childbirth and tracheostomies.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2003 BY COST



Source: MHS administrative data

DRG	DESCRIPTION
107	Coronary bypass w/ cardiac catheterization
148	Major small and large bowel procedures w/complications & comorbidities (cc)
209	Major joint & limb reattachment procedures of lower extremity
359	Uterine and adnexa procedures for non-malignancy w/o cc
370	Cesarean Section w/ cc
371	Cesarean Section w/o cc
372	Vaginal delivery w/ complicating diagnoses
373	Vaginal delivery w/o complicating diagnoses
391	Normal newborn
430	Psychoses
462	Rehabilitation
483	Trach. w/ mechanical ventilation 96+ hours or PDx except face, mouth & neck diagnoses
604	Neonate, birth weight 750–999g, discharged alive
622	Neonate, birth weight 2499g, with significant operating room procedure, with multiple major problems
626	Neonate, birth weight 750–999g, without significant operating room procedure, with multiple major problems

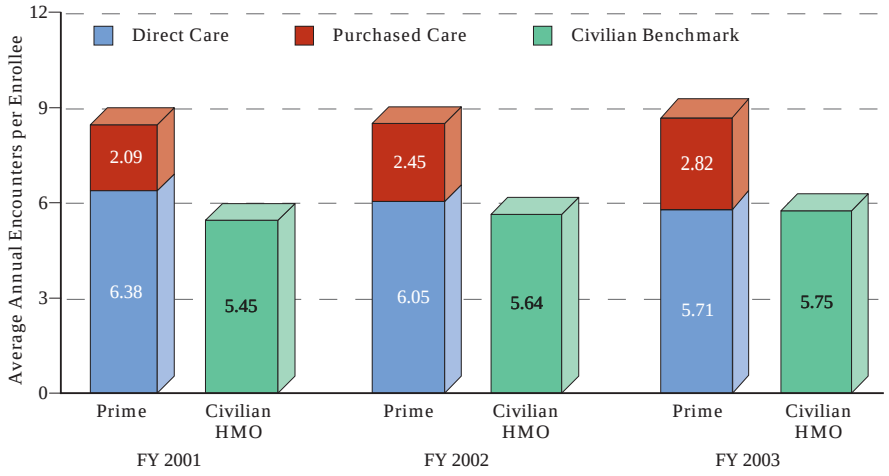
OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared to Civilian Benchmarks

TRICARE Prime Enrollees

- The total TRICARE Prime outpatient utilization rate (direct and purchased care utilization combined) remained essentially unchanged from FY 2001 to FY 2003, averaging about 8.5 encounters per enrollee.
- At the same time TRICARE Prime outpatient utilization remained steady, civilian outpatient utilization was increasing. Consequently, the disparity between total TRICARE Prime outpatient utilization and the levels observed in civilian HMOs narrowed in FY 2003. However, Prime enrollee outpatient utilization was still almost 50 percent higher than in civilian HMOs.
- Direct care outpatient utilization by Prime enrollees declined between FY 2001 and FY 2003 by 11 percent, whereas purchased care outpatient utilization increased by 35 percent.

OUTPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Clams and Encounters database

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

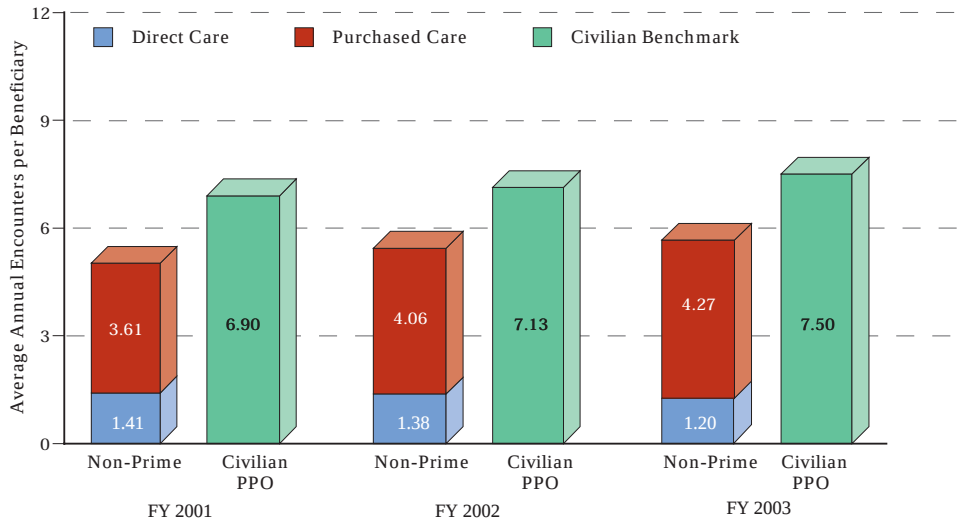
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Outpatient Utilization Rates Compared to Civilian Benchmarks

Beneficiaries Not Enrolled in TRICARE Prime

- The total TRICARE non-Prime outpatient utilization rate increased by 10 percent from 5.0 encounters per beneficiary in FY 2001 to 5.5 encounters in FY 2003. During this period, civilian PPO utilization rose at the same rate.
- Total TRICARE non-Prime outpatient utilization rates remained well below the levels observed in civilian PPOs. In FY 2003, TRICARE non-Prime outpatient utilization was 27 percent lower than civilian PPO utilization.
- Direct care outpatient utilization by non-Prime beneficiaries declined by 15 percent from 1.4 encounters per beneficiary in FY 2001 to 1.2 encounters in FY 2003.
- Purchased care outpatient utilization by non-Prime beneficiaries increased by 18 percent from 3.6 encounters per beneficiary in FY 2001 to 4.3 encounters in FY 2003.

OUTPATIENT UTILIZATION RATES: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

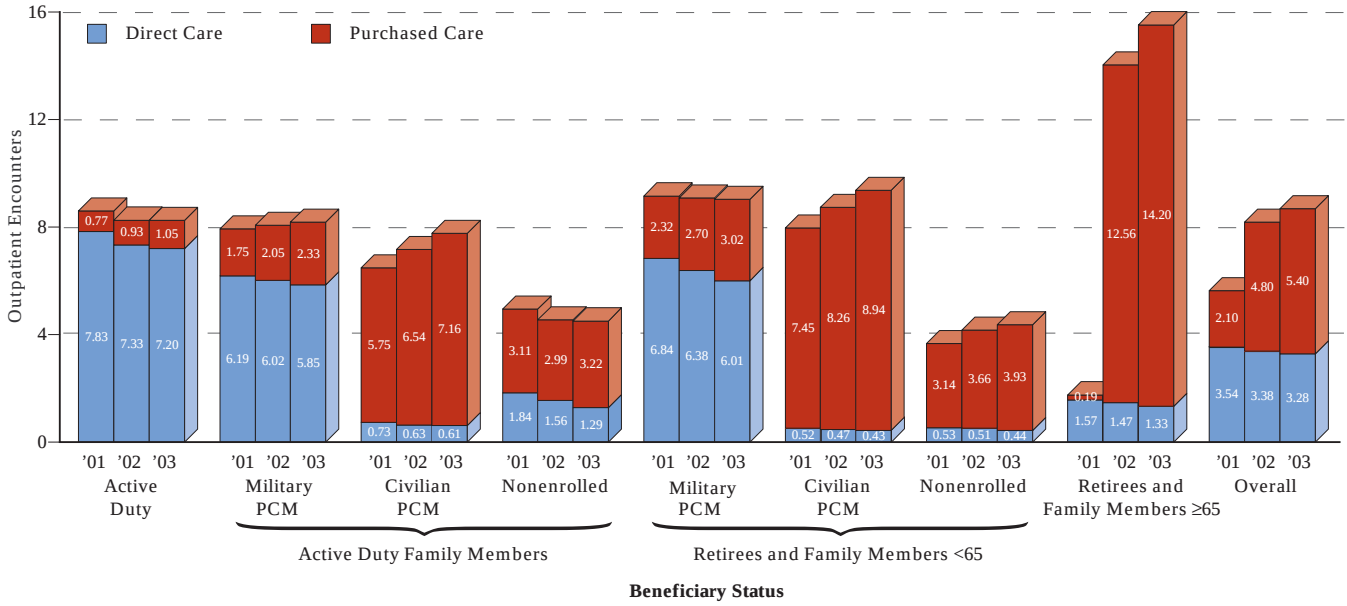
Outpatient Utilization Rates by Beneficiary Status

Direct care outpatient utilization declined between FY 2001 and FY 2003 for all beneficiary groups. The declines were most notable for beneficiaries enrolled with a military PCM.

Purchased care outpatient utilization increased for most beneficiary groups, especially those enrolled with a civilian PCM.

The reported utilization of DoD-sponsored outpatient care rose sharply for Medicare-eligible beneficiaries with the introduction of the TFL benefit in FY 2002. However, the apparent increase in utilization by these beneficiaries is illusory. Roughly the same levels of utilization were probably experienced in FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.

AVERAGE ANNUAL OUTPATIENT UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

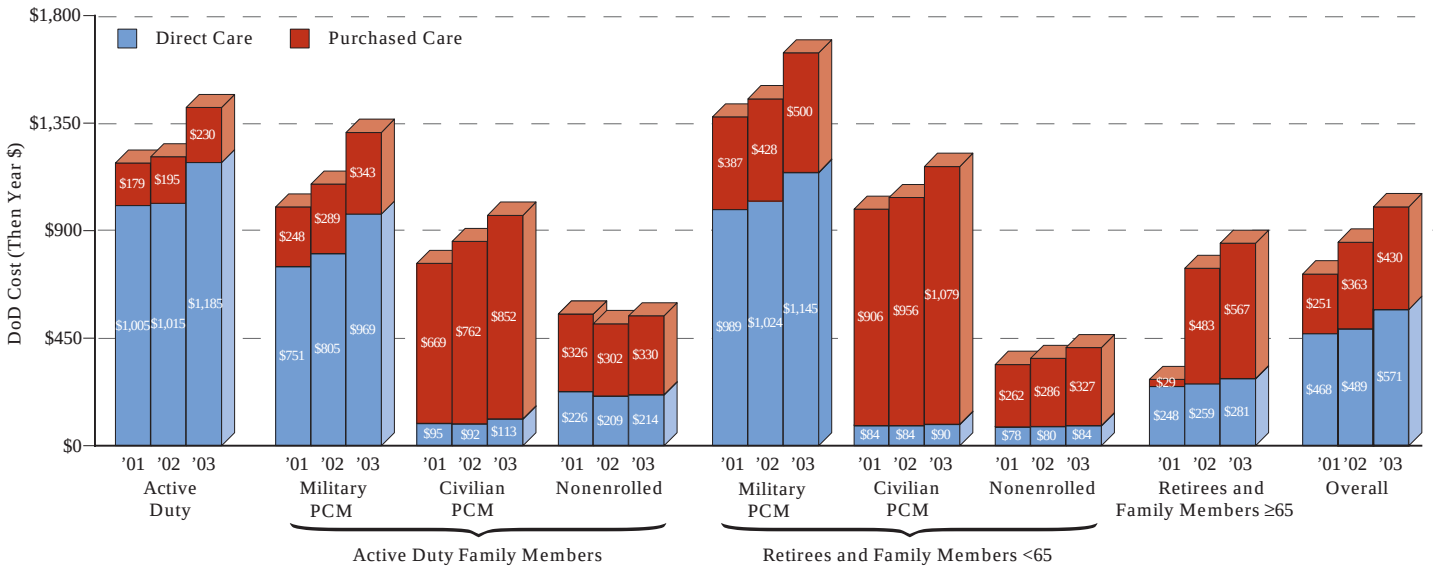
Outpatient Costs by Beneficiary Status

Even though direct care outpatient utilization declined for beneficiaries enrolled with a military PCM, DoD costs continued to rise. For all other beneficiary groups, DoD direct care costs remained essentially constant.

DoD purchased care costs increased for all beneficiary groups except nonenrolled ADFMs. The largest increases occurred for beneficiaries enrolled with a military PCM.

The large increase in DoD costs for Medicare-eligible beneficiaries is a result of the TFL benefit, first available in FY 2002.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

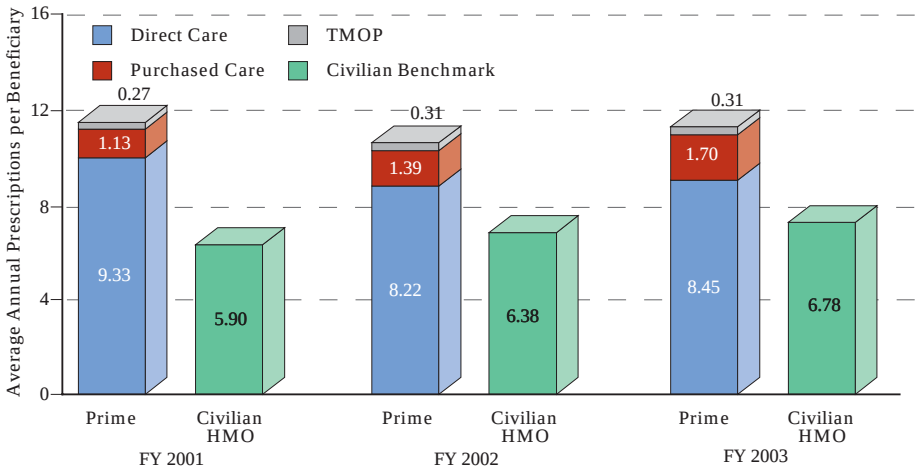
TRICARE Prescription Drug Utilization Rates Compared to Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, TRICARE Mail Order Pharmacy (TMOP) and MTF prescriptions can be filled for up to a 90-day supply whereas network prescriptions are usually based on 30 day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

TRICARE Prime Enrollees

- The total number of prescriptions per TRICARE Prime enrollee declined in FY 2002 but rose back to nearly the FY 2001 level in FY 2003. The TRICARE Prime prescription utilization rate remained more than 50 percent higher than the civilian HMO benchmark.
- Prescriptions filled for Prime enrollees at DoD pharmacies fell by 9 percent whereas prescriptions filled at network pharmacies increased by 51 percent from FY 2001 to FY 2003.
- Enrollee mail order prescription utilization increased by 12 percent in FY 2002 under the TMOP program and remained at the same level in FY 2003. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database.

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

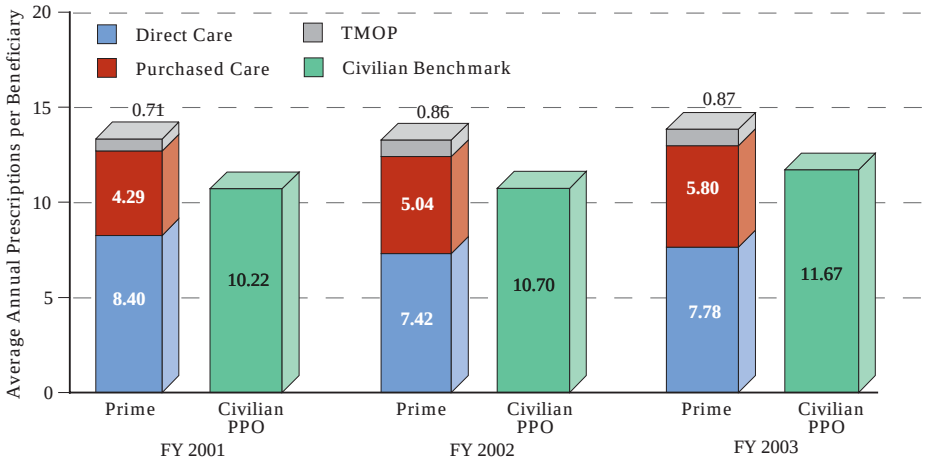
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Compared to Civilian Benchmarks

Beneficiaries Not Enrolled in TRICARE Prime:

- Total prescription utilization by non-Prime enrollees rose by 8 percent between FY 2001 and FY 2003. At the same time, civilian PPO prescription utilization rose by 14 percent. However, by the end of FY 2003, total prescription utilization by non-Prime enrollees was still 24 percent higher than their civilian PPO counterparts.
- Prescriptions per nonenrolled beneficiary filled at DoD pharmacies fell by 7 percent whereas prescriptions filled at network pharmacies increased by 35 percent. TMOP utilization increased by 22 percent but remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data and The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2003 civilian data are based on one quarter of data, which were seasonally adjusted and annualized.

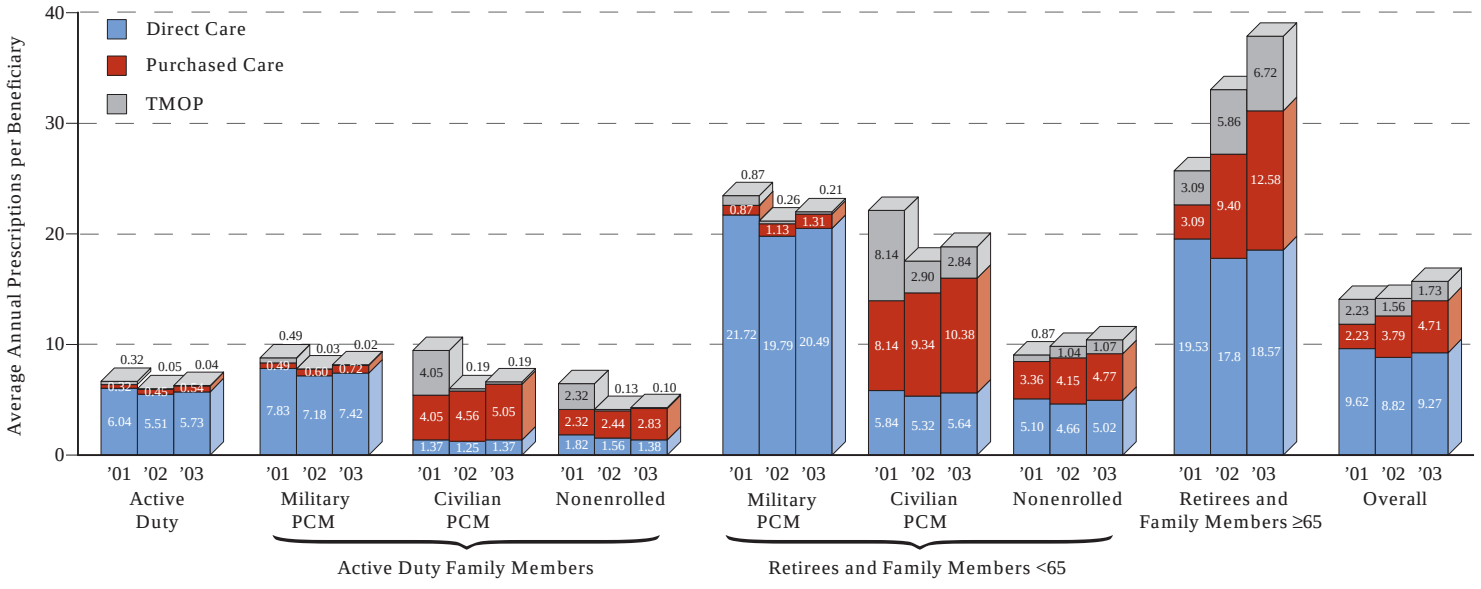
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and TMOP. Prescription counts from these sources were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

- The overall 23 percent increase in the number of prescriptions per beneficiary from FY 2001 to FY 2003 was largely due to the TSRx benefit.
- After dipping slightly in FY 2002, direct care prescription utilization rose back to its FY 2001 level for most beneficiary groups.
- Average prescription utilization through non-military pharmacies (civilian retail and mail-order) increased for all beneficiary groups but most notably for beneficiaries enrolled with a civilian PCM and nonenrolled retirees and family members. These beneficiaries are most reliant on network or mail-order pharmacies to fill their prescriptions.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data

Note: Detailed direct care prescription utilization data at the beneficiary level became available for the first time in FY 2002 with the advent of the Pharmacy Data Transaction Service (PDTS). Data from the PDTS were used to allocate total FY 2001 direct care prescriptions by beneficiary category and enrollment status.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS

Out-of-pocket costs are computed for *families* of MHS beneficiaries and compared with those of civilian counterparts. MHS families are grouped into (1) beneficiaries under age 65, and (2) beneficiaries age 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and premiums for various types of insurance. Civilian counterparts are civilian families with the same demographics as the typical MHS family. TRICARE and Medicare do not cover dental care and glasses. These costs are excluded since they are the same for MHS beneficiaries and their civilian counterparts.

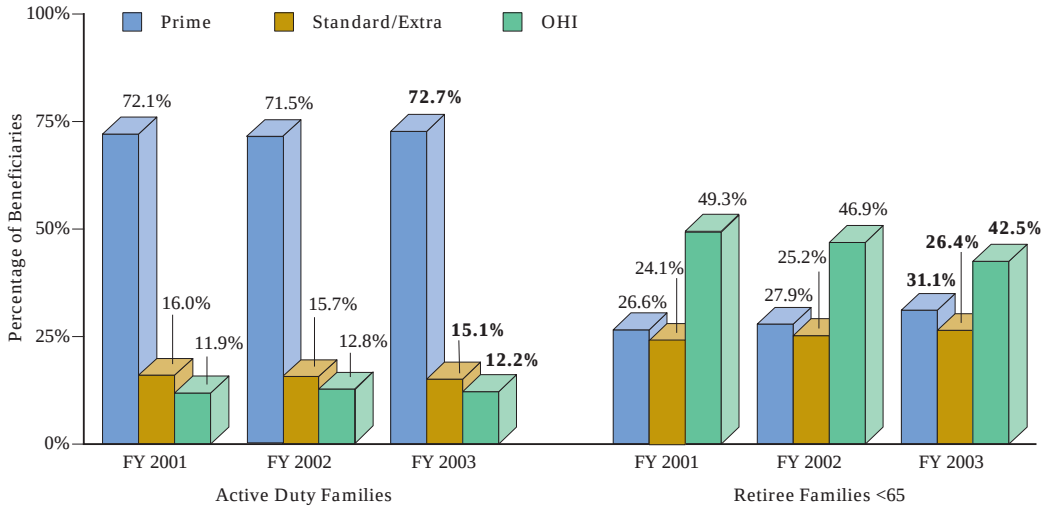
Health Insurance Coverage by MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard / Extra, and (3) other private health insurance (OHI). Some beneficiaries use OHI in combination with one of the TRICARE plans (in this case, TRICARE becomes second payer) whereas others opt out of TRICARE entirely. Civilian benchmark families are assumed to be civilian employees with employer-sponsored health insurance.

To make meaningful comparisons with civilian benchmarks, it is necessary to exclude MHS beneficiaries who use a combination of OHI and one of the TRICARE plans. The health insurance coverage of the remaining beneficiaries is:

- **TRICARE Prime:** Family enrolled in TRICARE Prime and no OHI. In FY 2003, 72.7 percent of active-duty families and 31.1 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and no OHI. In FY 2003, 15.1 percent of active duty families and 26.4 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2003, 12.2 percent of active-duty families and 42.5 percent of retiree families were in this group.

HEALTH INSURANCE PLAN USERS



Source: 2001–2003 administrations of the Health Care Surveys of DoD Beneficiaries

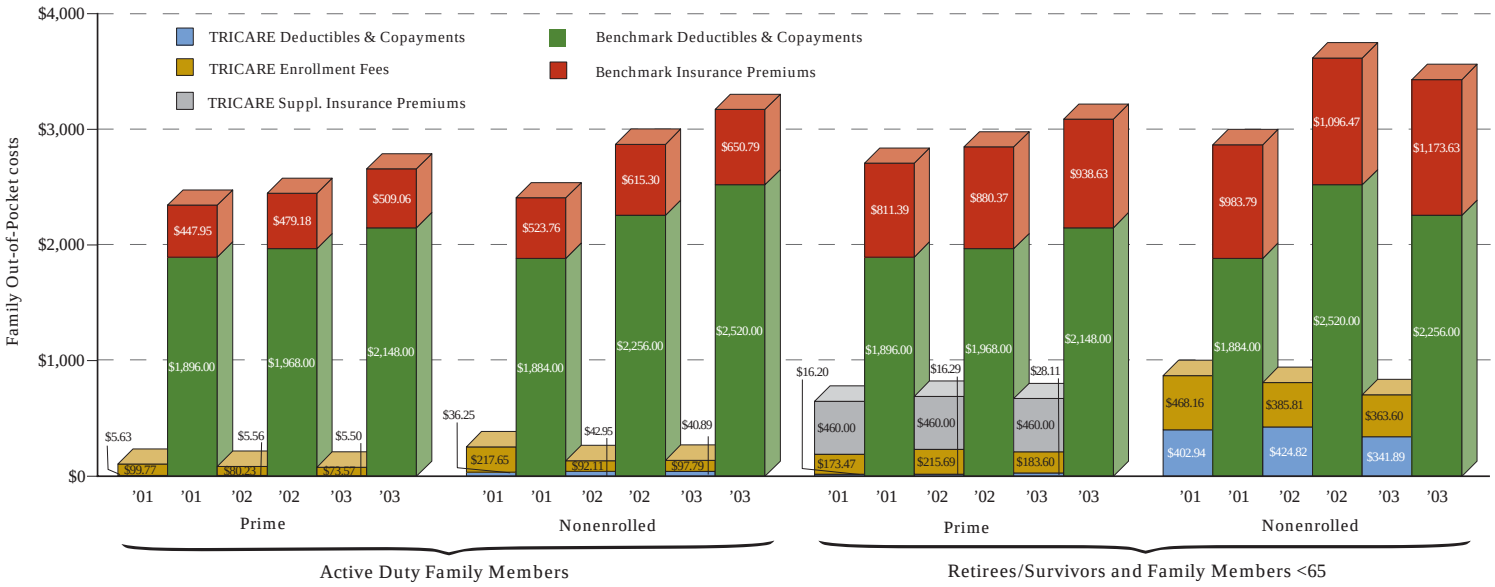
The Prime group includes Health Care Survey of DoD Beneficiaries (HCSDB) respondents without OHI who are enrolled in Prime based on DEERS. The Standard / Extra beneficiary group includes HCSDB respondents without OHI who are nonenrollees based on DEERS. The OHI group includes those with OHI based on HCSDB responses.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Out-of-Pocket Costs for TRICARE-User Families vs. Civilian Counterparts

TRICARE-user families have relatively low out-of-pocket costs: costs were $100 for active duty families and $700 for retirees in FY 2003. Civilian counterparts paid $2,400–$3,000 more for their health care, primarily because of insurance premiums and higher deductibles and copayments.

OUT-OF-POCKET COSTS FOR TRICARE-USER FAMILIES VS. CIVILIAN COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures: MHS administrative data; civilian expenditures: Medical Expenditure Panel Survey projections for 2001–03 adjusted for Consumer Expenditure Survey results; civilian insurance premiums: Kaiser Family Foundation Employer Health Benefits surveys, 2001–03; TRICARE supplemental insurance premiums: The Army Times, March Supplement, 2001–03; OHI and TRICARE supplemental insurance coverage: Health Care Surveys of DoD beneficiaries, 2001–03.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

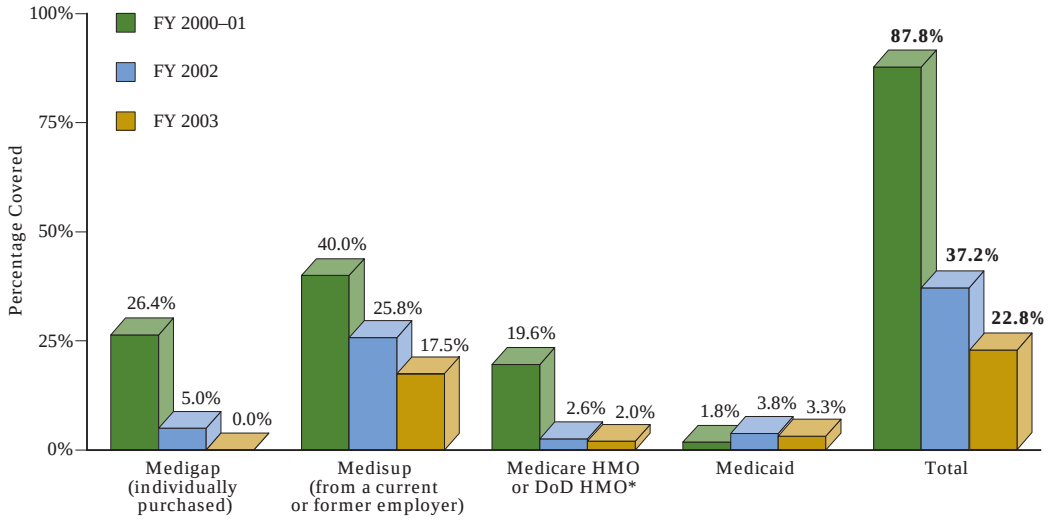
Health Insurance Coverage by MHS Senior Beneficiaries

Medicare provides insurance for medical care but there are substantial copayments / deductibles and it does not cover drugs. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance. A small percent were still active employees with employer sponsored insurance (OHI); a handful were covered by Medicaid. Out-of-pocket costs include deductibles and copayments, and premiums for Medicare Part B, supplementary insurance and OHI.

In April 2001 DoD expanded drug benefits for seniors, and on October 1, 2001 implemented the TFL program, which began essentially free Medicare supplemental insurance. Because of these new programs, most MHS seniors dropped their supplemental insurance. According to the Health Care Surveys of DoD Beneficiaries in 2000–03:

- Before TFL (FY 2000–01), 87.8 percent of MHS seniors had some type of Medicare supplemental insurance or were covered by Medicaid.
- After TFL, the percent of MHS seniors with supplemental insurance or Medicaid declined to 37.2 in FY 2002 and 22.8 in FY 2003.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS (%)



Source: 2001–2003 administrations of the Health Care Surveys of DoD Beneficiaries

* DoD HMOs include TRICARE Senior Prime in FY 2001 and the Uniformed Services Family Health Plan.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

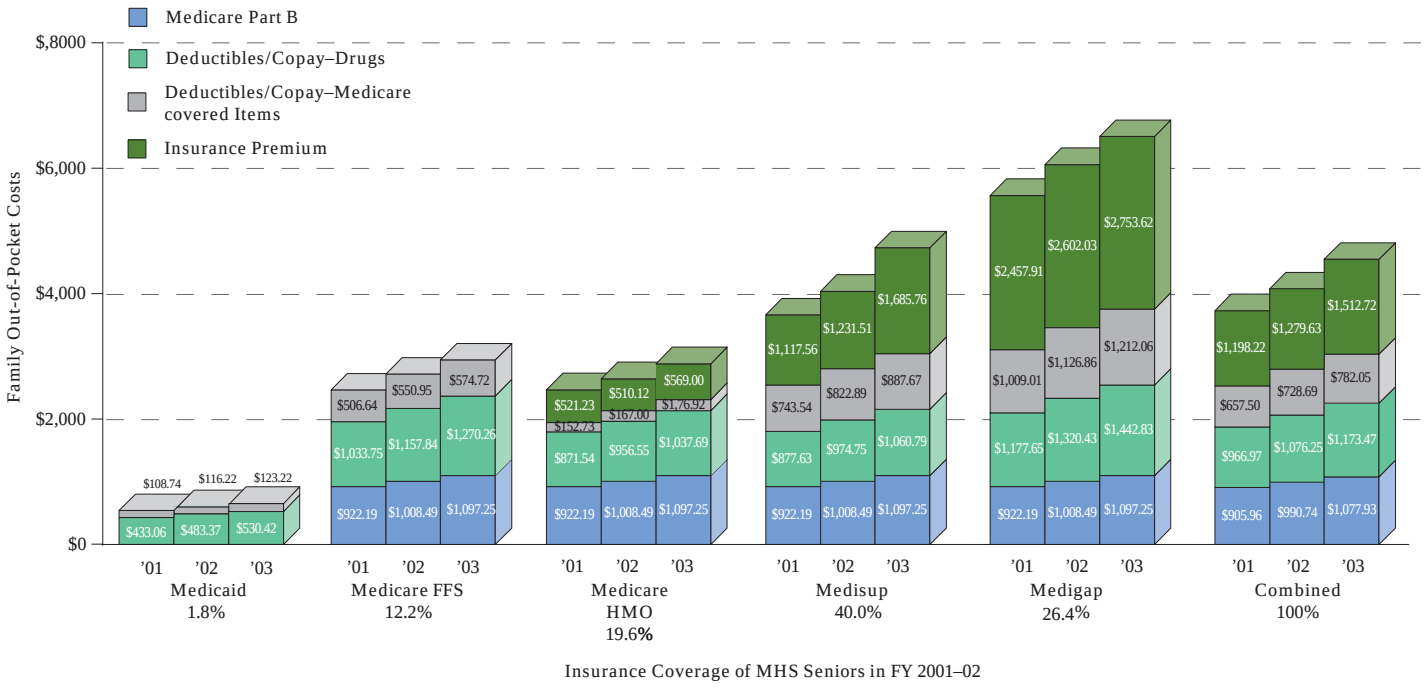
Out-of-Pockets Costs for Civilian Counterparts

Costs vary with Medicare supplemental insurance coverage. In FY 2003 costs for civilian counterpart families were:

- $6,500 for those with a Medigap policy
- $4,700 for those with a Medisup policy
- $2,900 for those enrolled in a Medicare HMO
- $3,000 for those without supplemental insurance (Medicare FFS)
- $700 for families covered by Medicaid.

Given the insurance coverage of MHS seniors before TFL (FY 2000–01), costs for a counterpart family would have been $4,500 in FY 2003. Costs for civilian counterparts rose sharply in FY 2001–03 because of increases in expenses for drugs and supplemental insurance.

ANNUAL (FY) OUT-OF-POCKET COSTS FOR CIVILIAN COUNTERPARTS OF MHS SENIOR FAMILIES



Insurance Coverage of MHS Seniors in FY 2001–02

Sources: Medicare supplemental insurance coverage of military beneficiaries: Health Care Surveys of DoD beneficiaries, 2001–2003; Medicare supplemental insurance coverage of civilian beneficiaries: Medical Expenditure Panel Survey projections for 2001–03 adjusted for Medicare Current Beneficiary Survey results; Medisup insurance premiums: Towers Perrin Health Care Cost Surveys, 2001–2003; Medigap insurance premiums: Weiss Ratings, Inc.; Medicare HMO and Part B premiums: Centers for Medicare and Medicaid Services

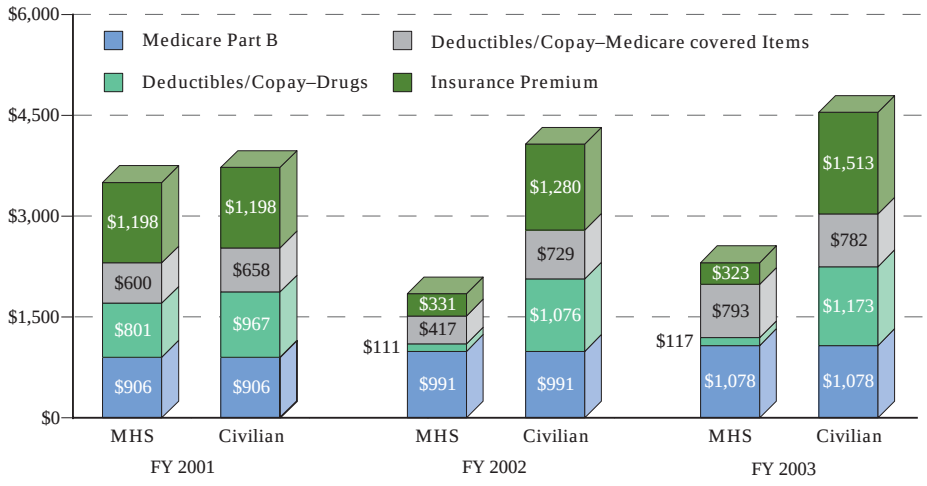
BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Out-of-Pocket Costs of MHS Senior Families vs. Civilian Counterparts

MHS seniors obtained relatively little of their medical care at MTFs and drug benefits were limited before April 2001. As a result, out-of-pocket costs for MHS seniors were only slightly less than their civilian counterparts in FY 2001. In FY 2002–03, out-of-pocket costs for MHS seniors were lower than they were in FY 2001 because of the enhanced benefits offered by TFL and TSRx.

- In FY 2001 costs for MHS senior families were about $200 less than their civilian counterparts.
- In FY 2002–03, costs for MHS senior families were about $2,300 less than civilian counterparts with "before TFL" supplemental insurance coverage.

OUT-OF-POCKET COSTS FOR MHS SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS



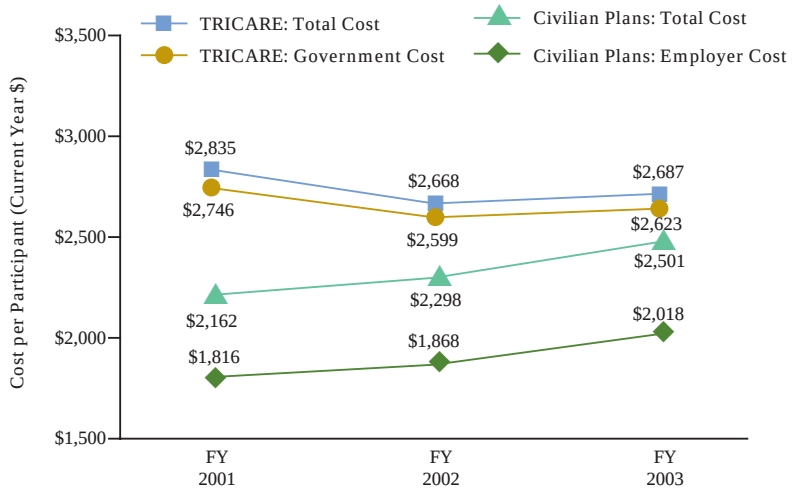
Sources: Medicare supplemental insurance coverage of military beneficiaries: Health Care Surveys of DoD Beneficiaries, 2001–2003; Medicare supplemental insurance coverage of civilian beneficiaries: Medical Expenditure Panel Survey projections for 2001–2003 adjusted for Medicare Current Beneficiary Survey results; Medisup insurance premiums: Towers Perrin Health Care Cost Surveys, 2001–2003; Medigap insurance premiums: Weiss Ratings, Inc.; Medicare HMO and Part B premiums: Centers for Medicare and Medicaid Services

Cost Per Participant

The DoD and total costs per participant are computed for MHS beneficiaries who rely on TRICARE exclusively for their care (i.e., Prime enrollees, and Standard / Extra users without private health insurance). The estimates exclude those with TFL. MHS readiness costs, which could not be separated from the peacetime health care benefit, are included. MHS costs are compared with the costs of civilian health plans offered by the nation's largest self-insured companies. Both the total and employer civilian plan costs are computed by summing costs of inpatient, outpatient, and prescription services used by plan participants and burdening the totals with administrative expenses. No health insurance premium data are used in the computations.

- The total cost (employer plus employee) per participant in FY 2003 was only 7 percent higher under TRICARE compared to self-insured health plans sponsored by large civilian employers.
- The gap between total TRICARE and total civilian health plan costs narrowed in FY 2001-03 because civilian health care costs increased substantially.
- TRICARE pays a higher proportion of costs per participant: 98 percent vs. 81 percent for civilian employers in FY 2003. The lower employee cost share under TRICARE increases utilization of MHS health care services.

TRENDS IN COST PER PARTICIPANT: TRICARE VS. CIVILIAN PLANS

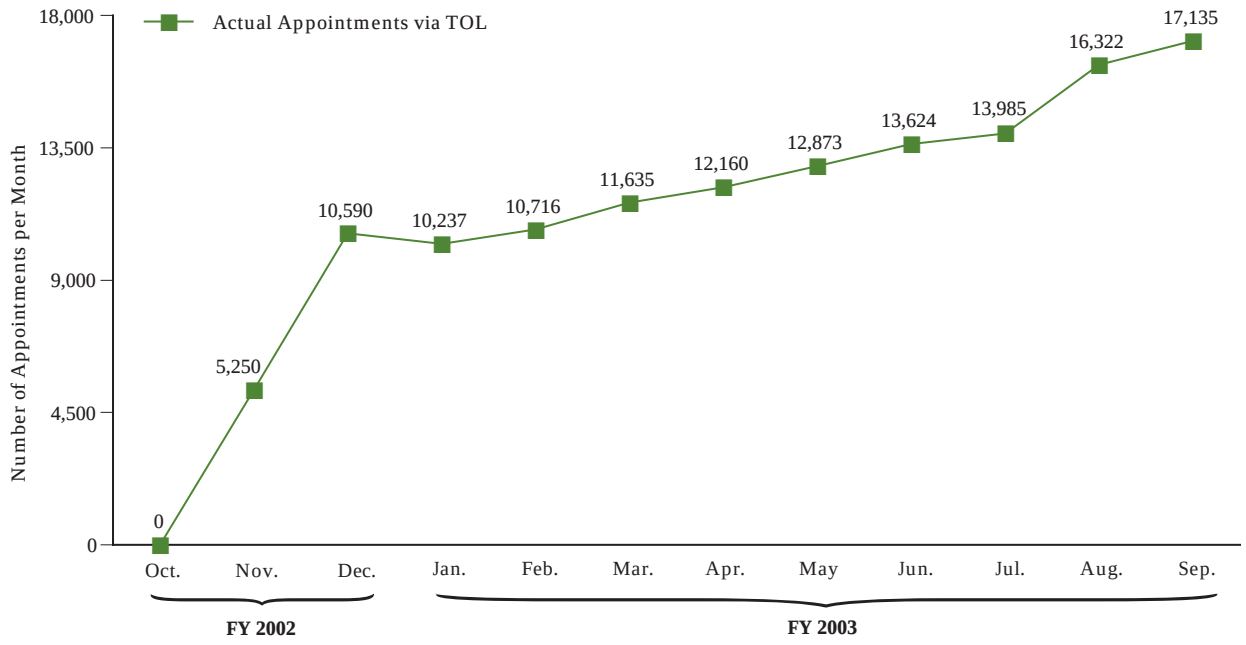


Sources: MHS administrative data; The MEDSTAT Group, Inc., MarketScan® Commercial Claims and Encounters database; and The Sherlock Company, 2001, 2002, and 2003 Sherlock Expense Evaluation Reports – Blue Cross Blue Shield Plans Edition

TRICARE ONLINE USAGE

TRICARE Online, www.tricareonline.com, is the new DoD Internet portal to interactive health care services and information. TRICARE Online was designed to meet DoD beneficiary needs for greater access and convenience in scheduling appointments, keeping a personal health journal and gathering information on medical and pharmaceutical care. TRICARE Online is a web site that is being developed in stages. When fully deployed, TRICARE Online will be universally accessible, portable and secure for registered users from any computer or laptop in the world. Beneficiaries will be able to use the Internet to make appointments or ask questions of the MTF. By September 2003, the system was deployed to 254 of 402 sites worldwide. There were 80,147 registered users who had made almost 18,000 appointments.

TRICARE ONLINE USAGE: NUMBER OF MONTHLY APPOINTMENTS



Source: MHS administrative data

GENERAL METHOD

In this year's report, we compared TRICARE's effects on the access to and quality of health care received by the DoD population with the general U.S. population covered by commercial health plans (i.e., excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the National Consumer Assessment of Health Plans Survey (CAHPS®). In addition, we examined several issues unique to the DoD population, such as intention to enroll and disenroll from TRICARE Prime, for which there is no external benchmark.

We also compared the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, we contrasted various TRICARE utilization and cost measures with comparable civilian-sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by The MEDSTAT Group, Inc.

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent three years of data (FY 2001 to FY 2003) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not add to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (1 October to 30 September).
- All dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from Internet web sites accessible by the public.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05. Analysis of survey data used for this report was completed the end of November, 2003.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

To fulfill 1993 National Defense Authorization Act requirements, the HCSDB was developed by the TRICARE Management Activity. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. (Source: TMA web site: http://www.tricare.osd.mil/survey/hcsurvey/).

The HCSDB is composed of two distinct surveys, the Adult and Child HCSDB, and both are conducted as large-scale mailed surveys. The Adult HCSDB is conducted once per calendar quarter every January, April, July, and October to a sample of all DoD beneficiaries worldwide. The Child HCSDB is conducted annually in the third quarter in July to a sample of DoD beneficiaries in the continental U.S. only.

Both surveys provide information on a wide range of health care issues such as the beneficiaries' ease of access to health care and preventive care services. In addition, the surveys provide information on beneficiaries' satisfaction with their doctors, health care, health plan and the health care staff's communication and customer service efforts.

HCSDB questions on satisfaction with and access to health care have been closely modeled on the CAHPS program. CAHPS is a standardized survey questionnaire used by civilian plans to monitor various aspects of access to and satisfaction with health care.

DATA SOURCES *(CONT'D)*

Health Care Surveys of DoD Beneficiaries (HCSDB)

CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful, reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups. Because the HCSDB uses CAHPS questions, TRICARE (DoD's health plan) can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at www.ahcpr.gov.

Tests of significance using the Benchmark data assume that the Benchmark data are measured without error. Comparison between years ignores possible changes in a population's age and health status. Prime enrollees are defined as those enrolled at least six months. Differences between the MHS and the civilian benchmark were considered significant at less than or equal to .05. The normal approximation is used.

Access and Quality

Measures of MHS access and quality were derived from the 2001, 2002, and 2003 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the National CAHPS Benchmarking Database (NCBD) for the same time period. The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc.

With respect to calculating the Preventable Admissions rates, both direct care and CHAMPUS workload were included in the rates. Admissions for patients under 18 years of age were excluded from the data. Each admission was weighted by its Relative Weighted Product (RWP), a prospective measure of the relative costliness of an admission. Rates were computed by dividing the total number of dispositions / admissions (direct care and CHAMPUS) by the appropriate population. The results were then multiplied by 1,000 to compute an admission rate per 1,000 beneficiaries.

Utilization and Costs

Data on utilization and MHS and beneficiary costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased care claims information) for inpatient, outpatient, and prescription services; and TRICARE Mail Order Pharmacy (TMOP) claims within each beneficiary category. Costs recorded on HCSRs were broken out by source of payment (government, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed by December 5, 2003.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans, including preferred provider organizations, point-of-service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked MEDSTAT to compute quarterly benchmarks for HMOs and PPOs, broken out by several sex/age group combinations. The quarterly breakout, available through the first quarter of FY 2003, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2003 data to completion. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

AD	Active Duty
ADFM	Active Duty Family Members
ASD	Assistant Secretary of Defense
BRAC	Base Realignment and Closure
CAHPS®	Consumer Assessment of Health Plans Survey
CC	Complications and Comorbidities
CCAE	Commercial Claims and Encounters
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CNA	Center for Naval Analyses
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DoD	Department of Defense
DRG	Diagnosis-Related Group
DVA	Department of Veterans Affairs
FFS	Fee for Service
FY	Fiscal Year
GDP	Gross Domestic Product
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HMO	Health Maintenance Organization
HP	Healthy People
IDA	Institute for Defense Analyses
MHS	Military Health System
MTF	Military Treatment Facility
NCBD	National CAHPS® Benchmarking Database
NDAA	National Defense Authorization Act
NOAA	National Oceanic and Atmospheric Administration
OASD	Office of the Assistant Secretary of Defense
OHI	Other Health Insurance
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
PHS	Public Health Service
POS	Point of Service
PPO	Preferred Provider Organization
SADR	Standard Ambulatory Data Record
SIDR	Standard Inpatient Data Record
STS	Specialized Treatment Service
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Total Obligation Authority
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRFDP	TRICARE Reserve Family Demonstration Project
TRO	TRICARE Regional Office
TSRx	TRICARE Senior Pharmacy
UMP	Unified Medical Program